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Chemist&Druggist
The Newsweekly for Pharmacy

C&D

21 August 2004

Concern over entry control changes 'leak'

Scots facing 10pc discount clawback

Medicines for children put in the spotlight

NPA chairman Ash Soni talks to C&D

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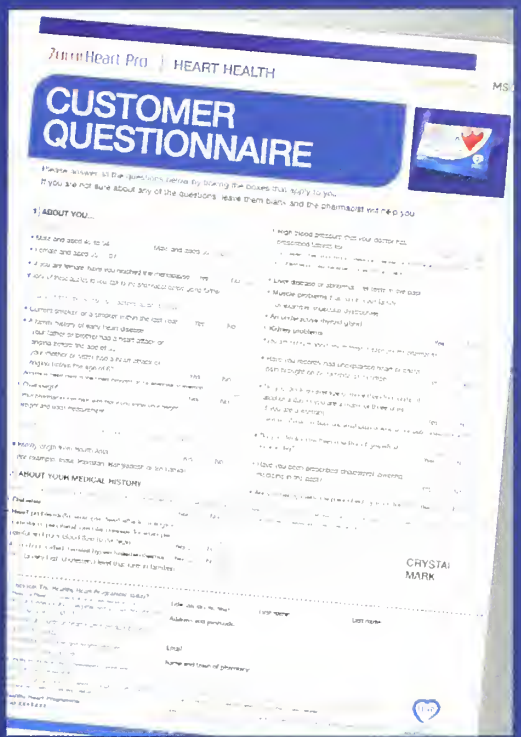
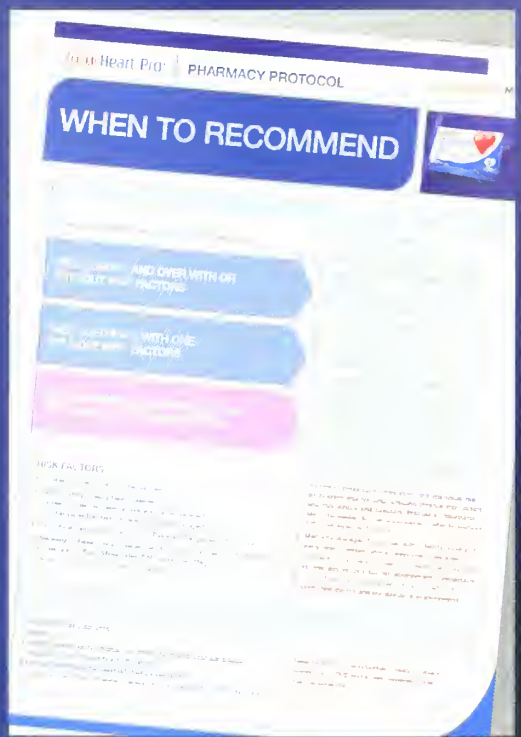
Essential Information
Product Name: Zocor Heart-Pro® 10mg tablets. **Presentation:** Peach-coloured, oval-shaped tablets containing simvastatin 10mg. **Indications:** To reduce the risk of a first major coronary event (non-fatal myocardial infarction and coronary heart disease (CHD) deaths) in individuals who are likely to be at moderate risk (approximately 10-15% 10 year risk of a first major event) of CHD. **Dosage and Administration:** Take one 10mg tablet daily at night. Not recommended for paediatric use. **Contraindications:** Hypersensitivity to simvastatin or any of the excipients; previous history of muscular toxicity with a statin or fibrate; individuals already taking prescription cholesterol lowering drugs; concomitant administration of potent CYP3A4 inhibitors (e.g. itraconazole, ketoconazole, HIV protease inhibitors, erythromycin, clarithromycin, telithromycin and nefazodone); active liver disease or unexplained persistent elevations of serum transaminases; pregnancy and breast-feeding; women of childbearing potential. **Precautions:** Zocor Heart-Pro® is not intended for individuals who are known to have: existing coronary heart disease, diabetes, history of stroke or peripheral vascular disease, familial hypercholesterolaemia.

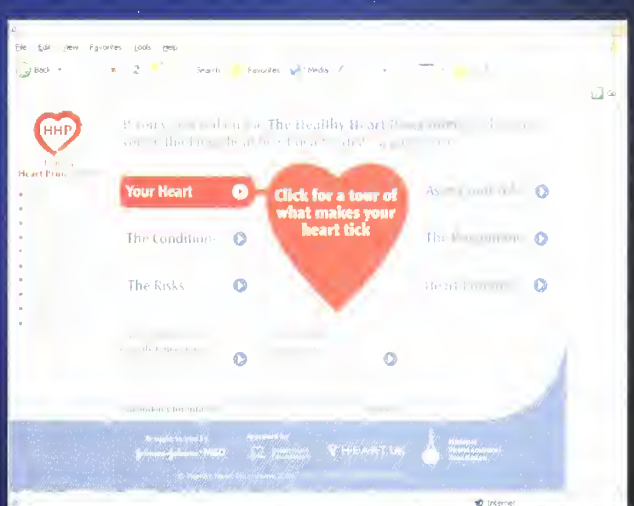
The Zocor Heart-Pro® Support Programme.



Self-completion customer forms, to help you easily identify customers at moderate risk.



You'll have a reference guide to help you know when to recommend.

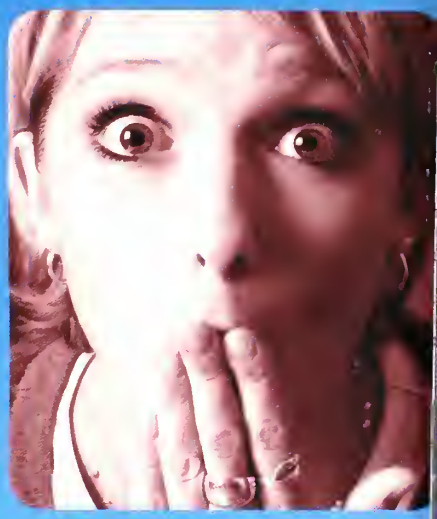


You'll be able to direct enquirers to the online Healthy Heart Programme, (www.heartpro.co.uk) for further lifestyle advice and support.

dividuals with hypertension should consult their doctor before undertaking treatment. Individuals with a fasting LDL-cholesterol level of 5.5 mmol/l or reater should consult their doctor. All individuals must be advised of the risk of myopathy and told to stop taking Zocor Heart-Pro® if they experience nexplained generalised muscle pain, tenderness or weakness. People aged >70 years or with hypothyroidism, renal impairment, personal or family history f hereditary muscle disorders should not take Zocor Heart-Pro® except on medical advice. Product should be used with caution and under medical upervision in people who consume substantial quantities of alcohol and/or have a history of liver disease. If treatment with itraconazole, ketoconazole, rythromycin, telithromycin or clarithromycin is unavoidable, therapy with Zocor Heart-Pro® should be suspended during the course of treatment. oncomitant use with potent inhibitors of CYP3A4, e.g. ciclosporin. Individuals with rare hereditary problems of galactose intolerance, the Lapp lactase eficiency or glucose-galactose malabsorption should not take this medicine. **Side Effects:** Most commonly reported side effects were: abdominal pain, onstipation, flatulence, asthenia, headache. The following side effects have also been reported: anaemia, paraesthesia, dizziness, peripheral neuropathy, yspepsia, diarrhoea, nausea, vomiting, pancreatitis, hepatitis/jaundice, rash, pruritus, alopecia, myopathy, rhabdomyolysis, muscle cramps, myalgia. oparent hypersensitivity syndrome has been reported rarely. Increases in serum transaminases, alkaline phosphatase and serum CK levels. **Legal ategory:** P. **PL Number:** PL 13249/0039. **PL Holder:** Johnson & Johnson•MSD Consumer Pharmaceuticals, High Wycombe, Buckinghamshire HP10 JF, UK. **Packaging Quantities:** 28 tablets. **Price:** £12.99 (RRP). **Date of Preparation:** May 2004.

Oops...

Are your customers troubled by bladder weakness?



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The National Continence Check-up. Giving your customers the right solutions.

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www.incontact.org
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The Continence Foundation
www.continence-foundation.org.uk
registered charity number 1014429

TENA
www.tena.c

In association with these leading continence charities.

www.dotpharmacy.com

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This week

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Winterton: safeguards will ensure protection

Details of how changes to the control of entry regulations will apply to community pharmacies in England have been published.

Pharmacies may obtain an NHS contract without fulfilling the regulations' "necessary or desirable" tests if they fall into one of the following categories:

- open for 100 hours a week
- located in a primary care centre
- located in a 15,000sq metre retail development
- internet or mail order based.

However, with the stated aim of protecting the network of independent community pharmacies, health minister Rosie Winterton has stipulated that certain conditions must be met to qualify for exemption. And key to the exemption categories is that applicants must provide a full and prescribed range of services, determined locally by the PCT for the first three exemptions, and the DoH and NHS for internet services.

The minister has stressed that such opportunities are open to independent pharmacies, not just the big multiples. "Pharmacists will also have a right to open up shops in shopping malls in out-of-town retail centres. This will allow enterprising pharmacists to take competition to the supermarkets," she said.

In addition to the four exemption categories, the Government has announced that an automatic exemption will be introduced for all minor relocations under 500 metres, but the discretion for PCTs to over-ride this where there is good cause will be retained. It will also be possible for minor relocations across PCT boundaries.

New criteria of "competition and choice" will be introduced through secondary legislation.

NHS dispensing in rural areas is also to be addressed in tandem with these reforms and that of the new pharmacy contract.

Views on the changes

Commenting on the proposals, Ms Winterton said: "This improves services for patients and those who use pharmacies, with safeguards to ensure that we support community pharmacists, many of whom are small businesses. This should not lead to widespread closures."

PSNC chief executive Sue Sharpe responded by saying that PSNC has been working to ensure that the four exemptions were subject to controls that would minimise the damage they would do to the present network of community pharmacies.

"We are pleased to see that the Department has agreed that town centre shopping developments of 15,000sq m should not be exempt from the control of entry regulations. The provisional list of 386 premises has therefore reduced to 124, and of these, several are distinct developments within larger shopping areas."

She described the minister's decision to restrict the size exemption as a "very substantial improvement" which "will provide reassurance for large numbers of pharmacies".

Mrs Sharpe added: "On balance, this is far better than the position we faced 18 months ago – complete deregulation. It is also a substantial improvement on last summer."

Numark, however, is worried about the use of 'competition and choice' in deciding new contract applications. Andrew Sollitt, Numark's marketing director, said: "Our concern is surrounding 'competition and choice': what are the criteria and what are the tests going to be? At the extreme you could deliver deregulation through competition and choice; there's no definition from the DoH as to what it means." He was concerned that the changes will be made under secondary legislation, which means they may not be debated by Parliament, nor would pharmacy bodies be able to have any input into what the tests would look like.

Brian Cotter MP, Liberal Democrat spokesman for small business, said: "If a pharmacy is granted the right to set up business purely on the basis that it will be open for 100 hours a week, it should be a prerequisite that a pharmacist will be on site for the duration of that time.

"If the DoH or primary care trusts cannot monitor that criterion, then they are simply advocating 100-hour-a-week shampoo shops. Today's report completely ignores the fact that small, independent pharmacies may be squeezed out of a big boys' market. This, in turn, will restrict consumer choice.

"Local pharmacies provide essential services for the elderly and vulnerable groups in our communities and it is imperative that the Government removes the death warrant it has effectively placed on these vital small businesses," added Mr Cotter.

More reaction to the news is carried on page 19.

The safeguards

- Those wanting to qualify for the '100 hours' exemption will have to prove to their PCT that they are prepared to provide extra services, such as smoking cessation.
- For consortia intending to open in primary care centres, the rules will stipulate that the pharmacy will have to offer a full range of pharmaceutical services and that the centre will generally have to service a population of around 20,000.
- Internet or mail order pharmacy businesses must provide a "fully professional service", and meet the standards required of other pharmacies as set out by the RPSGB.
- To qualify for exemption on the 15,000sq m development grounds, the site must not be in the town centre – the terms "out of centre" and "out of town" are being used – and the area requirement must be fulfilled by retail elements only and not, for example, car parking spaces.

Chiefs in the dark

Pharmacy chiefs first realised there was going to be an announcement this week after reading reports in last weekend's Sunday papers. PSNC was contacted first, on Saturday, by a journalist from the *Sunday Times*, and immediately posted a website statement. On it, PSNC chief executive Sue Sharpe said: "PSNC would need to see the detail of the proposals for changes to control of entry within large retail developments in order to be able to accurately evaluate the extent to which they would damage the existing good network of locally accessible pharmacies. Too many pharmacies in shopping centres will inevitably lead to the closure of neighbourhood pharmacies."

NPA chief executive John D'Arcy admitted that the NPA had not been pre-warned of the announcement and, as of close of play on Tuesday, was preparing statements on the "assumption" that the announcement would relate to the 'balanced package of measures' previously outlined by the Government in its response to the OFT's report on the control of entry regulations, published in January 2003.

Mr D'Arcy admitted that he, too, would be looking for detail and exact definitions for the expected exemptions from Ms Winterton's announcement, and was hoping to see the full report of the advisory committee on the control of entry regulations consultation. As of Tuesday, he had only seen the executive summary.

£2m Scottish contract fund is quid pro quo

Scottish contractors' payments are to be subject to an average proprietary discount clawback rate of 9.97 per cent, effective from July, the Scottish Pharmaceutical General Council has announced.

However, in return the Scottish Executive Health Department has also agreed to put up £2 million to fund infrastructure investment in support of the new pharmacy contract. SPGC estimates that around one quarter of the fund will be used for staff training. The pre-registration grant is also to increase by £1,260 to £6,000.

In its negotiations with the SEHD, which followed the discount enquiry conducted last September, the SPGC has secured two additional concessions: the first relates to the broken bulk facility which, from August, will also now apply to the supply of NHS dressings, provided they are individually wrapped and sterile integrity is maintained.

In addition, SPGC has won a compensation payment for contractors when the Practitioner Services Division (PSD) identifies a net error rate of greater than 0.2 per cent. This is effective from August. There will be no general adjustment where the error is to the advantage of the contractor, the SEHD has agreed.

Commenting, SPGC chairman Frank Owens said: "The savings achieved through discount recoveries are only generated by the considerable efforts of community pharmacy. These efforts are now being recognised by the reinvestment programme."

The deal also lists new reimbursement prices for lisinopril, doxazosin and simvastatin, which are effective from July 1 (*see table*). The SEHD says the simvastatin price in particular has been set to support both clinical objectives and the needs of contractors.

Reimbursment prices effective July 1, 2004

Drug	strength	pack size	reimbursement price
Lisinopril tablets	2.5mg	28	£2.96
	5mg	28	£3.56
	10mg	28	£4.70
	20mg	28	£6.80
Doxazosin tablets	1mg	28	£2.43
	2mg	28	£2.85
	4mg	28	£3.64
Simvastatin tablets	10mg	28	£5.50
	20mg	28	£8.80
	40mg	28	£12.60
	80mg	28	£24.00

Pharmacy in centre

The new £11m NHS one-stop centre being built in Stapleford, Nottinghamshire, will include a pharmacy.

The new centre, which also houses two GP practices, minor injuries and out-patient clinics, social services and mental health departments, is being built as part of the NHS Local Improvement Finance Trust (LIFT) initiative, and is one of five such sites being developed in the area over the next 18 months. Patients should be able to use the centre in early 2006.

Euro health cards

The Department of Health is proposing to introduce into the UK a new European health insurance card. This will bring the UK into line with other European nations and will replace the current 'E-forms', in particular the E111, which are used by European citizens to prove their entitlement to free or reduced cost emergency medical treatment during temporary stays in other European countries.

Itching 9-5

An employer's guide to contact dermatitis is being launched to coincide with National Eczema Week, September 18-25, which is themed: 'Itching 9 to 5 – working with eczema'. This outlines tips on managing contact dermatitis in the workplace, which includes providing soap substitutes and allowing emollient application time.

NE APTUK meeting

The North East region of the Association of Pharmacy Technicians UK has announced that APTUK president Darren Leech will be speaking at its meeting next month.

The meeting will be held at 7pm on September 29 at the Samsung Conference Centre near Hartlepool and non-members are welcome. Anyone interested should contact Brian Moulder on 01429 279695 or at *brian.moulder@nth.nhs.uk* or Angela Kielly on 01642 624362 or at *angela.kielly@nth.nhs.uk*

NRT helps teens

A smoking cessation scheme for schoolchildren has been set up in County Durham by Sure Start health promotion worker Jaimie Battye and school nurse Moya White.

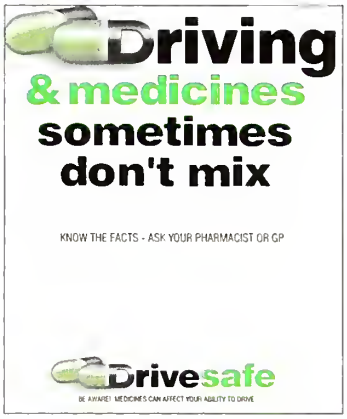
The teenagers must have parental and GP consent before they can start using nicotine replacement therapy. The NRT is supplied for up to 12 weeks through a voucher scheme.

Campaign stresses risk of driving on some medicines

by Asha Fowells
afowells@cmpinformation.com

Scottish pharmacies have this week launched a campaign highlighting the effects some medicines can have on driving ability.

Led by the Scottish Road Safety Campaign in partnership with NHS Scotland, the campaign will see pharmacies throughout Scotland using posters, fliers and pharmacy bag stickers to raise awareness of the issue. The campaign material reminds patients to ask their pharmacist or GP if their OTC or prescription drugs have the potential to affect driving capability.



Scottish Road Safety Campaign assistant director Anne Diack said the campaign would be ongoing but the focus would shift to concentrate on particular groups of medicines, such as cough and cold remedies this winter and hay fever products early next year.

Scotland's chief pharmaceutical officer Bill Scott said: "Even though many medicines are available over the counter, there may still be certain risks attached – certain treatments can cause drowsiness and driving when tired is very dangerous."

For more information:
www.srsc.org.uk/publicity/medicines_and_driving.asp

Thousands respond to OTC programme

Thousands of people have called or e-mailed the BBC following its *Real Story* exposé on the problem of OTC analgesic abuse.

Many got in touch after the programme to praise the BBC for drawing attention to such an under-estimated problem, while others questioned whether the programme was an attempt to get such drugs switched to POM.

Said one caller: "Ninety nine per cent of the population will have to take time off work, flood overworked surgeries and generally suffer for the unfortunate few who can't [sensibly use these drugs]."

In response, a BBC spokesman said: "Many people were previously unaware that it was possible to become hooked on these common medicines."

The programme, *'Real Story's Painkillers: cure or risk?'* was shown on BBC One on August 9. It reported the video diaries of two adults attempting to overcome addictions to over the counter painkillers, Solpadeine and co-codamol. In both cases, the subjects of the film accepted that they were knowingly exceeding the manufacturers' instructions and stated warnings.

GSK said it viewed the misuse of OTC medicines seriously but said there is no evidence to suggest ingredient levels in any GSK product, including Solpadeine, will cause dependency when used as directed.

Overcount, a self-help charity supporting more than 13,500 OTC medicine addicts, estimates that the two diarists are among 30,000 Britons with the problem – 70 per cent of whom are women.

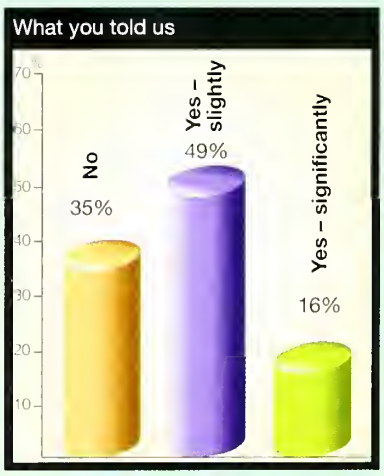
Questiontime

Last week we asked you: "Do you think raising the RPSGB's annual membership fee by £51 to £256 and revising the membership categories will reduce pharmacist numbers?" You replied (see right):

This week's question: How do you view the changes to the control of entry regulations for community pharmacies announced by the DoH this week?

● Don't go far enough ● Generally positive ● Would prefer the status quo ● Worried about the consequences ● No opinion

You can record your vote on our website: *www.dotpharmacy.com*. You have until noon on August 24 to cast your vote. We will publish the results in *C&D*, August 28.



PRACTICE

Joint effort on diabetes scheme

North West London Strategic Health Authority is planning a pilot scheme with Pfizer and GSK to discover how diabetes patients use PCT services.

The partnership aims to establish a baseline of how patients with diabetes access Hounslow PCT's services in accordance with the recommendations from the *National Service Framework on Diabetes*. When the results are available in September, the stakeholders hope to work with eight PCTs to deliver the requirements of the diabetes NSF, said NWLSHA diabetes lead Geraint Davies.

There may be opportunities for community pharmacy in the future. Mr Davies added that the PCT was "very keen to explore the opportunities afforded by the NSF and the new pharmacy contract to provide services in a different way in the future".

GSK has already been involved with a public-private partnership with an asthma medication review pilot in 75 pharmacies across the UK. The project was designed to "up-skill" pharmacists in preparation for the new pharmacy contract, rather than offer a monetary reward.

A spokesman for GSK said the project, which aimed to review over 1,000 asthma patients, was well received and popular. The company expects data from the pilot to be available by the end of August.

MULTIPLE

Co-op offers pub health checks

Co-operative Group pharmacists are offering health checks in pubs, clubs and community centres.

Pharmacists from the four stores trialling the scheme will offer customers cholesterol and blood pressure tests to assess their heart disease risk as well as give advice on healthy lifestyles and statin use.

The scheme is being trialled in Milton Keynes, Yeadon near Leeds, Culcheth near Warrington and Ballynahinch in Northern Ireland.

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esentation: 5% w/w aciclovir in water miscible cream base. **Uses:** Treatment of Herpes Simplex virus ections of the lips and face (cold sores). **Dosage and administration:** Apply 5 times a day for 5 days. It is portant to start treatment as early as possible after the start of infection, ideally during the tingle phase. If aling has not occurred, treatment may be continued for up to an additional 5 days. **Contraindications** Known hypersensitivity to aciclovir or propylene glycol. **Precautions**: Only to be used on cold sores on the lips and face. Do not apply inside the mouth or in the eye. Do not use for herpes infections of the eye or the genital area. Do not use if the patient is under the care of a doctor because of a weak immune system. Consult doctor if pregnant or breast feeding. **Side effects:** Transient burning or stinging may follow application. Mild drying or flaking of the skin has occurred in about 5% of patients. Erythema, itching and contact dermatitis have been reported rarely following application. **Legal category:** P. **Product licence number:** 00003/0304. **Product licence holder:** The Wellcome Foundation Limited, Greenford, Middlesex, UB6 0NN, U.K. **Further information available on request from:** Medical and Consumer Affairs, GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP:** 2 g tube - £5.99; 2 g pump - £6.19. **Date of last revision:** March 2004
Zovirax is a registered trade mark of the GlaxoSmithKline group of companies.

gsk GlaxoSmithKline Consumer Healthcare

References:
1. Spruance SL *et al.* Antimicrob Agents Chemother 2002; **46**(7):2238-43. 2. Spruance SL. Seminars in Dermatology 1992; **11**(3): 200-206. 3. Van Vloten WA *et al* J Antimicrob Chemother 1983; **12**(Suppl B): 89-93 4. Fiddian AP et al. Br Med J 1983; **286** 1699-1701. 5. Data on file, GlaxoSmithKline, 2001.

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*Source: ACNielsen latest MAT w/e 3/7/04

Minister calls for focus on child medicines

by Sasa Janković
sjankovic@cmpinformation.com

Health Minister Lord Warner has called on pharmaceutical companies to focus on the needs of children when developing new medicines.

Launching a new initiative to encourage the development of more medicines designed for use in children, he highlighted the fact that most medicines are designed for and tested on adults but are widely prescribed for children. He said children and adults respond very differently to medicines and a treatment which is effective in adults may not be as suitable for children.

These new plans will encourage manufacturers of medicines to research and develop medicines geared to the needs of children. They will also make sure prescribers have better information about the impact of medicines on children.

The new paediatric medicines strategy includes strongly encouraging companies to provide much better paediatric clinical trial data for new and current medicines; provide better information on the use of medicines on children in patient information leaflets; and investing part of the additional £100 million announced in the Budget to promote research into medicines for children through new research networks which will be co-ordinated by the UK Clinical Research Collaboration.

For the first time, a separate *British National Formulary for Children* will also be published.

Lord Warner said: "Until now there hasn't been enough emphasis on developing medicines specifically for use in children, and the UK has led the way in pushing for change in this area. Work is in progress on a *British National Formulary for Children* and we provide funding for its publication and distribution as soon as it is ready. I want the new strategy to give a strong message to pharmaceutical companies to focus on the needs of children when developing new medicines. Health professionals need the latest information so that they can make the right choices about the medicines and treatments for their younger patients."

The ABPI has welcomed the move, saying: "We are proud of our record of moving things forward in terms of paediatric medicines, but the European Directive is taking a very long time to come through."

For more information:

www.dh.gov.uk
www.abpi.org.uk

New BDM for UniChem

UniChem has appointed Mario Johnson (above) as business development manager within the strategy and marketing department at the company's Chessington head office.

He joins UniChem from international logistics company DHL International, where he helped launch its Worldwide Medical Express Service.

As business development manager, his principal activity is to identify areas for development and innovation pilots, in order to confirm their benefits to UniChem. In addition, he will lead the implementation of Customer Relationship Management.

IT

NDCHealth Corporation to sell European arm

NDCHealth Corporation intends to sell its European operations as a going concern.

Simon Driver, managing director of NDCHealth in the UK, said: "The European operations in the UK and Germany are in advanced talks with a number of investors and we hope to have an announcement by the end of October.

"However, it is business as usual and our products and services will continue. We see this as a positive move to gain investment which will be good for us and our customers."

In addition, NDCHealth Corporation reported its financial results for the fourth quarter and fiscal year ended May 28, 2004. Total revenue increased to £239.6 million from £228.5m in the fiscal year ended May 30, 2003.

RETAILING

Co-op Group adds Welsh eleven to its tally

Co-operative Group Pharmacy has bought 11 pharmacies in South Wales from Howard & Palmer Ltd for an undisclosed sum.

All 78 staff from the pharmacies in Cardiff, Newport and Gwent will transfer to the Co-operative Group and the branches will be rebranded.

John Makepeace, Co-operative Group Pharmacy general manager, said: "The purchase of these three businesses is part of our ambitious programme for development and expansion. Co-operative Group Pharmacy is already strong in South Wales and the acquisition of these pharmacies adds substantial market share, including a well developed prescription collection and delivery service which we want to extend to other nearby Co-operative Group pharmacies."

Customers order at Dawn

Colorama Pharmaceuticals has launched its Dawn touch-screen ordering system.

Customers in pharmacies can choose personal care, electrical and beauty products from the touch-screen shop, pay at the pharmacy counter and pick up the goods the next day. For more information call 0870 040 0030.

Numark own-brand sales up

Numark has announced record own-brand sales to end of June 2004 of £3.6 million, up 15.5 per cent on the same period last year. June was a record breaking month with sales just short of £700k. Numark's private label range of over 350 lines is currently seeing very strong performance.

Celesio success

Celesio's results for the first half of 2004 showed turnover up 3.7 per cent over the previous year to £6.304.8 million. Pre-tax profit rose by 23.3 per cent to £139m.

Dr Fritz Oesterle, chairman and chief executive officer, said: "In wholesale we intend to increase turnover in local currency in line with the comparable market."

BMS fined £82m

Bristol Myers Squibb is to pay £82 million to settle charges of using fraudulent accounting practices. The Securities and Exchange commission accused the US drug giant of inflating sales by encouraging wholesalers to overstock its products and recognising the revenue too soon.

Vaccines deal

Provalis has signed an option agreement with Chiron Vaccines giving Chiron an initial 12 month, exclusive option (extendable by a further 12 months on payment of a fee) to evaluate Provalis's protein based vaccine candidates to prevent Group B Streptococcus infection.

Sandoz buys Durascan

Sandoz has bought Durascan, the generic subsidiary of AstraZeneca in Denmark, in a transaction aimed at claiming the number two position in the Danish generics market and establishing a new operational hub in the Nordic region. Financial details of the transaction were not disclosed.

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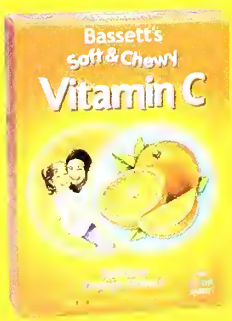

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*Source: Information Resources, All outlets, 52 w/e 15 May 2004.

INDUSTRY

5-in-1 jab adviser has MSD links for medical research

by Sasa Janković
sjankovic@cmpinformation.com

The chairman of the Joint Committee on Vaccination and Immunisation, which advised Government on changes to childhood immunisation, receives industrial support from the 5-in-1 jab's supplier.

In the JCVI's Declaration of Members' Interests, Professor Michael Langman lists the support he receives from Merck Sharp & Dohme for his medical research at Birmingham University as a 'non-personal interest'.

Changes to the childhood immunisation programme were announced last week at the Department of Health (*C&D, August 14, p23*) following advice from the JCVI.

Newspapers put the chairman in the spotlight earlier this week as opposition parties called for improved governance regarding links between government and industry.

The DoH pointed out that Prof Langman had not received any personal benefit from vaccine producer Aventis Pasteur MSD since he was appointed JCVI chairman.

The changes involve using inactivated polio vaccine (IPV) instead of live oral polio (OPV) vaccine for all ages, and using a new acellular pertussis vaccine instead of whole cell pertussis vaccine to protect babies and children against whooping cough. This new acellular pertussis vaccine provides the same high level of protection but tends to cause fewer minor reactions.

Health minister John Hutton said: "Immunisation is the best way to protect children from serious disease and the routine childhood programme has been extremely effective in achieving this. The changes set out will further improve the programme and benefit children. The polio component is safer than the previous oral vaccine and the switch to acellular pertussis will mean children are less likely to suffer from minor reactions such as swelling and redness."

The new primary, pre-school and teenage vaccines will be introduced from late September.

ENGLAND

Bradford IPI becomes CIC

Bradford University's Institute of Pharmaceutical Innovation is to become a Centre of Industrial Collaboration in Yorkshire.

Launched by Yorkshire Forward to help businesses exploit research, it will be a centre of excellence in pharmaceutical science, accelerating the drug development process.

Last year, Yorkshire Forward became the first Regional Development Agency to establish a network of CICs, an £11 million initiative with the European Regional Development Fund to establish a world-class scientific, technical and research resource for industry.

Led by Paul Thorning, a former market research director for AstraZeneca, Bradford's IPI-CIC draws on expertise in computational prediction to develop novel formulations and drug delivery systems. It aims to target established pharmaceutical and healthcare companies, new bio-science start-up companies, suppliers to the industry and other companies needing to optimise formulations.

For more information:
www.yorkshire-forward.com

RETAILING

Retailers halt changes to injury scheme

Pressure from retailers has halted a Government decision to make changes to the scheme that compensates victims of crime and violence at work.

The proposed changes to the Criminal Injuries Compensation Authority Scheme would have scrapped state-funded compensation. Instead employers would have been responsible for compensating victims, costing the retail sector an estimated £10 million a year.

Kevin Hawkins, director-general of the British Retail Consortium, said: "Violence against staff is a serious problem, causing distress to both staff and their employers – but retailers should not be penalised for the criminal behaviour of members of the public and should not be made responsible for incidents beyond their control.

"The BRC has fought hard for this victory. We are very happy with the Government's decision and glad the voices of retailers have been heard."

For more information:
www.brc.org.uk

EDUCATION

Moss funding available

Moss Pharmacy is inviting applications for financial support from the Harold and Marjory Moss Charitable Trust for the academic year starting next October. Applications will be considered from:

- undergraduates who cannot start or finish a pharmacy course due to financial hardship
- dispensers who have secured a place to study pharmacy and are in financial need
- PhD students undertaking research that will benefit community pharmacy.

For more information:
rachel.marchant@mosspharmacy.co.uk
Tel: Rachel Marchant on 020 8751 8364.

INDUSTRY

OFT reviews IMS Health

The Office of Fair Trading is reviewing undertakings given by pharmaceutical data supplier IMS Health in 1999 when it bought Pharmaceutical Marketing Services.

The main provisions of the undertakings required IMS Health to divest itself of PMSI's former business supplying pharmaceutical data, which it has since done, and to license prescription data to third parties.

The OFT is examining the current state of competition in the market to see whether the undertakings, in whole or in part, need to be retained or can be released, varied or superseded.

Interested parties are invited to give their views to the OFT.

For more information:
Ingrid.nitsche@oft.gsi.gov.uk
Tel: Ingrid Nitsche on 020 7211 8461

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COLORAMA Pharmaceuticals

Dawn

Comment from the Editor

Our question to pharmacists this week was: Do you think raising the RPSGB's annual membership fee by £51 to £256 and revising the membership categories will reduce pharmacist numbers?

"Yes, it will. I know it's less than doctors pay, but we don't get paid as much as them"

Anon, Dundee

"I think the higher fee may push pharmacists nearing retirement to give up altogether"

Judith Taylor, Kendal

"It's not really a lot of money so I don't think it would influence anyone's decision"

Eduardo Toribio, Eccles

If you work for a multiple they pay it for you anyway"

Terri Galappathie, Pontefract

Wednesday's announcement regarding the changes to the control of entry regulations for community pharmacies in England has aspects which can be admired. The Government has clearly rejected the Office of Fair Trading's recommendation for a complete deregulation and has now given more detail on what it was proposing in its 'balanced package of measures'. There will be no return to the days of 'leap-frogging' so characteristic of an unregulated market.

Pharmacies offering a service that patients want should not have too much to fear. And as the method of service provision changes under the new contract, pharmacists will be able to decide which form of practice suits them best – remaining primarily dispensing based or taking on the new cognitive roles. Patients will need both sorts of service and will look out for the ones offering the best.

But there are still many gaps in the details. What is meant by 'competition and choice' exactly? Does having the new 'choice' of deciding which out-of-town shopping mall or supersurgery to go to mean anything to the elderly or infirm when the public transport infrastructure may be lacking and their local community pharmacy may have had to close or relocate while dealing with the 'competition' aspect?

The Government is also not yet in a position to publish in full the report put together by the Advisory Group set up by the DoH to develop the 'balanced package of measures'. It says it has accepted many of the recommendations but doesn't say which ones it has not, nor why. Is there something that contractors may fear?

And what about rural dispensing? Pharmacists, GPs and dispensing doctors came to an agreement several cabinet reshuffles ago, but the matter has been in abeyance while waiting for these contract reforms.

Then there's that matter of the legislative changes. Those being put through under secondary legislation could avoid full parliamentary scrutiny, and there is also the question of parliamentary time being needed. If we are heading into a general election, what are the chances that a piece of pharmacy legislation will get the attention it deserves?

Despite these concerns, the minister does seem to have been able to convince the Treasury that healthcare cannot be subject to normal market forces. And she has also been keen to stress that she wants the community pharmacy network to continue. Without it, the ambitious healthcare aims that the Government has set out will founder.

The minister is insisting that pharmacy standards will not be allowed to fall short

It is reassuring to see, too, that the minister is insisting that pharmacy standards will not be allowed to fall short and that PCTs will be given the power to take pharmacies off the list if they do not comply with the standards and service provision that all pharmacies will have to comply with, whether 'real' or 'virtual'.

This week's proposals cannot be seen in isolation. The new pharmacy contract is what these control of entry regulations are all about. Reading the Department's proposal, the signs are that the contract is nearing a significant stage, ahead of seeking the approval of contractors.

Now that the control of entry changes are in the open, a degree of stability will return to the profession. Pharmacists will be able to plan and to consider how they will take on the challenge of a new contract, rather than worry about too many unknowns.

INDUSTRY VIEWPOINT

A force for the future?

The future of pharmacy is going to be more complex, with a multiplicity of professional and commercial demands on the profession.

If it is true that only the female of the species is capable of true multitasking, could it be argued that pharmacy in the future will be more suited to women? During the past 10 years the number of female pharmacists has grown rapidly and for years female pharmacy undergraduates have substantially outnumbered their male counterparts.

The trend is not specific to pharmacy and the reasons are complex but two main drivers come to the fore.

First is the acceptance that women can and should pursue a career in these professions. Second and more recent is the rise of female dominance in academic achievement.

It is not difficult to see why pharmacy is so suited to women. It combines academic rigour with human interaction. Dealing predominantly with young mothers and children or the elderly, successful pharmacists will increasingly require a combination of science and interpersonal skills.

Successful pharmacists will require a mix of science and interpersonal skills

There remains one area where female pharmacists are rare: the pharmacy contractor. This would explain why there have been female presidents of the RPSGB and members of Council but very few on the committee of PSNC or the board of the NPA.

Once the new contract is implemented and multitasking becomes a necessity, perhaps this last bastion of male dominance in pharmacy will also be challenged.

Written by a senior pharmaceutical industry manager

TOPICAL REFLECTIONS

The retention fee lottery

The erratic nature of the increases in our retention fees suggests that the Society doesn't have a long-term business plan. A 25 per cent increase this year was preceded by two years where the increase was five per cent or less, while in 2002 there was a 31 per cent hike.

A tax-deductible £51 is not a massive problem for most pharmacists. But there seems some uncertainty whether the simultaneous introduction of a two-tier structure will increase the total money collected. Some of those currently paying the part-time or over 60s fee may only work a handful of days and decide that £256 along with increasing professional requirements mean it's not worth remaining on the Register. A £50 fee may prove too high for some non-practising pharmacists simply to receive the *Pharmaceutical Journal*. If the total take does not increase sufficiently I expect to be in line for another large increase next year.

While this fee compares favourably with other professions, I still need to pay my NPA and LPC fees. And these other professions' retention fees have helped secure them significant wage rises and important changes in their practice. That's what I call good value for money.

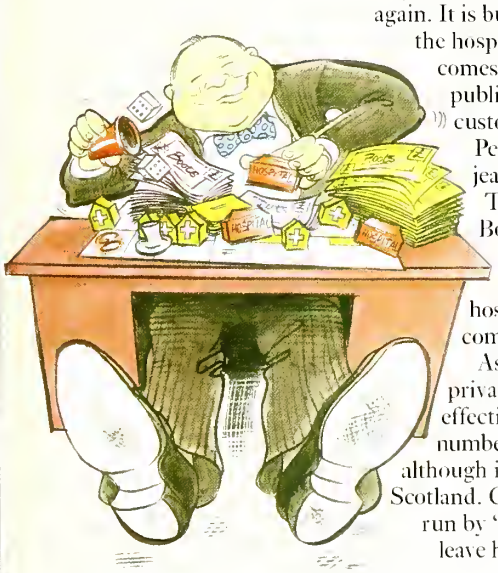
Too slow with the good vaccine news

The Department of Health's hash of a positive story about the introduction of the new five in one vaccine left health professionals in the lurch and will surely cause another drop in vaccination rates. The premature leaking of the story provided time for all manner of stories to spread before the Government's message was out.

The story broke on the Sunday, before doctors were due to be told on the Tuesday. This left a variety of misinformation free to circulate throughout the media on Monday and supposedly well informed professionals unprepared for questions and criticisms. It is exactly this sort of bad PR that feeds media interest in the vaccination issue.

I was left to answer queries based on my interpretation of what I'd heard on the radio and read in the newspaper. My information from the DoH did not arrive in the post until the Friday, the same day as I could read the story in *C&D*. I'm not the first place people come for information on vaccination, but surely the more sources of correct information available, the more effectively the message will be spread? Pharmacists should be given this sort of information as early as possible to help stop misinformation in its tracks.

What's Boots up to?



After a period of consolidation and time for the new chief executive to get his feet under the table, Boots seems to be seizing the initiative again. It is buying up more pharmacies and getting a foothold in the hospital sector (*C&D, August 14, p11 and 12*). This news comes shortly after the announcement that Boots is forming public-private partnerships to make the NHS more customer friendly.

Perhaps I'm being overly suspicious or maybe I'm simply jealous that I can't get involved in these sorts of schemes. The hospital pharmacy contract sounds like a great idea: Boots can bring a wealth of expertise to this PFI hospital in a cost-effective manner, leaving the hospital staff free to concentrate on patient care. I don't know if other hospitals already contract out their pharmacy services to community groups, but I'm sure there will be many more.

As most previously state owned industries have shown, privatisation and contracting out expensive services is highly effective and saves a lot of money. Contracting out large numbers of hospital pharmacies seems unlikely at this stage, although it seems to have worked well within the prison service in Scotland. Could community and hospital pharmacies end up being run by 'the big three' pharmacy chains, and where would this leave hospital pharmacists?

Ple@se e-mail your views to chemdrug@cmpinformation.com

Timely decision on harassment and bullying at work

I was pleased to read of the Council's decision to incorporate a statement on harassment and bullying into the Council *Governance Handbook* and the Society's *Employee Handbook*, but equally surprised to realise that such a statement was currently lacking.

The statement adds: "The Society will not tolerate any harassment, bullying or victimisation." Has this not always been the case?

The insidious and heinous act of bullying must be quashed, particularly as victims are usually unable to defend themselves.

Let us now hope that our profession is at last taking effective measures to ensure that it has a powerful system in operation, able to identify, expose and deal with bullying, both external and within.

Let us also hope that all previous and present occurrences of harassment and/or bullying have been detected and dealt with in a fair, correct, open and timeous manner.

HV Stewart,
Perthshire

Who should claim credit for Charter?

I was interested to read your article by RPSGB immediate past president Gill Hawksworth (*C&D, August 7, p11*).

It is unfortunate that she feels the need to claim the credit for the new draft Charter which is presently being voted on by the membership. She also claims she contributed this solution in her "last duty as president".

This is incorrect. She had ceased to be president weeks before the meetings that hammered out the final version of the new Charter, having lost the confidence of Council by continuing to advocate the previous flawed draft.

If there is any credit due with regard to the final draft, the one which the membership is voting on, then it is due to the new officers, and the members of the old Council who sought to work constructively with the new members of Council elected in 2004 under the SOS banner.

I agree with Dr Hawksworth when she advocates a 'yes' vote, and I appreciate that she has made a huge contribution over the years to the profession as a whole. But when it comes to the new Charter let's have credit where credit is due.

Maurice Hickey,
RPSGB member of Council

Window of opportunity to back the Charter?

I am glad to see Gillian Hawksworth calling for members to vote in favour of the draft Charter achieved under Nick Wood's presidency (*C&D, August 7, p11*).

There would, of course, have been no need to take advantage of any window of opportunity, however caused, if the draft Charter that had been sent by a divided Council to the Government last December had been one that members generally could support.

Douglas Simpson,
RPSGB member of Council

Editor's note: The RPSGB offered editors the opportunity to have an article written by a member of Council regarding the referendum on the new draft Charter. I asked for an article from the Immediate Past President Dr Hawksworth to reinforce the message that all sides of Council were calling for a 'yes' vote.

NPA does not include dispensing doctors

Xrayser (*C&D, August 7, p15*) referred to Terry Hannawin resigning from the NPA Board in protest at dispensing doctors being allowed to join (*Dispensing GPs taking over the world*).

The NPA would like to make it clear that dispensing doctors are not eligible for NPA membership. The NPA Board made the decision to amend the Articles of the Association to allow all pharmacy owners into membership. This includes pharmacies wholly or partly owned by doctors. However, as dispensing doctors do not operate from registered pharmacy premises, they are not 'pharmacy owners' and are therefore not eligible for NPA membership.

Geraldine Clark,
NPA senior press officer

The Metropolitan Police have adopted Raid-control – a scheme set up to reduce robbery in retail premises and piloted in Croydon – to fight gun crime in London. Raid-control pools the expertise of the police, the security industry and retailers. Detective chief superintendent Sharon Kerr, head of Serious and Organised Crime OCU, said Raid-control offered practical guidance to independent retailers who may have found it challenging to handle their own crime prevention measures. The initiative has its own website at www.raid-control.org

Controlled change or slippery slope?

While there has been a positive response that there will not be complete deregulation, the initial reaction to the announcement on the changes to the control of entry regulations has been mixed

The NPA is "fully supportive of the aim to strengthen the pharmacists' role and to improve access by greater choice". However, it argued that community pharmacy is in the business of healthcare rather than retail.

John D'Arcy, the NPA's chief executive, commented: "We need now to carefully examine the fine details of the proposals because we have real concerns about the possible unpredictable impact of the exemptions – particularly the one-stop primary care centres and the 15,000sq metre exemptions. The exemptions must be implemented in a way that makes their use an exception to the rule – thereby minimising their impact on existing services.

"What we mustn't have is 'deregulation through the back door'. The opening of new pharmacies under the new exemptions could serve to suck business away from existing pharmacies. If this happens, existing pharmacies may be forced into reducing the level of services on offer. And in extreme cases, existing pharmacies may be forced into closure."

This was a point echoed by Numark. Marketing director Andrew Sollitt was concerned that the introduction of competition and choice' as a new test could allow deregulation. "We are committed to maintaining a national network of community pharmacy, to ensure needs of the elderly, the infirm and the socially excluded are met," he said.

However, Moss Pharmacy's managing director, Steve Duncan, pointed out that the initial test of necessary and desirable would still be the basis. He also felt that pharmacies that are already providing a good service to patients should not have too much to fear. However, he warned: "We do not want five years of judicial reviews like the last time the regulations were reviewed. There should be sufficient directional guidance so that that is avoided."

He also argued that the proposals should be seen generally positively, as there was further clarification on a number of matters, but he said he would welcome more detail on strategic service development plans to ensure pharmacy was able to contribute fully.

He was not prepared to comment on how the changes will affect Moss's planning, but pointed out that as the proposed package had been around since last summer, Moss had been considering its plans. He thought there would not be too many pharmacy contracts granted under the 15,000sq m exemption, or the 100 hours.

> **"... we have real concerns about the possible unpredictable impact of the exemptions..."**
>
> John D'Arcy

A spokesman for Boots, however, said that it expected that it could introduce NHS contracts into about 50 of its stores, currently without a contract, once the legislation was amended. "Our view is that we welcome it. Pharmacy is very much at the core of our business so anything that makes it easier for us to offer services to customers makes it a good thing."

Referring to the way the news was handled by the national press, he said reporters were getting a little carried away about 24 hour openings. He pointed out that there is a shortage of pharmacists and there will also be costs involved in opening new pharmacies and employing pharmacists to cover the hours.

The Royal Pharmaceutical Society said that it would be considering the impact of the plans from the perspective of sustaining patient access to local community pharmacy services.

Nicholas Wood, the president said: "Throughout the long gestation of the Government's package of measures, we have sought reassurance that people will continue to have access to a local community pharmacy convenient for where people live and work and the range of health services that pharmacists provide.

"Local access is particularly important to the elderly, to mothers of young children and to people struggling on low incomes ... it is crucial that pharmacists continue to be accessible to everyone."

The Society will be requesting a meeting with the minister to discuss the plans "at the earliest opportunity".

Nucare was "disappointed" by the news that the new rules will allow an automatic right to open a pharmacy in large developments but not in town centres. It is also concerned that PCTs will not be able to properly plan pharmacy services across its locality.

Nucare cited its recent patient survey of 7,200 customers in 1,200 pharmacies, given the choice, 99 per cent wanted the pharmacy to stay where it was and not be moved into a supermarket. "A long-standing relationship with shop staff was also important to over 85 per cent of patients, and no significant gaps were identified in the range of, and access to, high quality pharmacy services."

Mahesh Shah, Nucare's managing director, said: "Whilst we support the principles of competition and choice, this must be compatible with a planned network of pharmacies. Within pharmacy, where over 80 per cent of the turnover is related to NHS prescriptions, principles of competition cannot be viewed in the same light as in truly free markets. Nucare believes the proposals under 'competition and choice', and the four exemptions are in effect proposals to deregulate the market.

"We believe that the proposals, if implemented, will have irreversible consequences on local community pharmacies, and that consumers and patients, especially the most vulnerable in our society, will suffer from reduced levels of care, service, choice and competition. What's more, they are at odds with the findings of the devolved powers in Scotland, Wales and Northern Ireland who rejected the proposals outright."

Martyn Ward, UniChem's sales and marketing director, said the announcement was broadly in line with what was expected. "The legislation has been carefully structured to offer protection to community pharmacy. UniChem is fully aligned with what the Department of Health is striving for and we will continue to support community pharmacy as a recognised key player in the provision of NHS services," he said.

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Derek Balon describes how the ageing process can affect the actions of drugs

Drugs and the elderly

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Objectives

- To review the physical and mental changes of ageing
- To be aware how these affect body systems
- To understand drug pharmacokinetics
- To know which drugs pose particular risks
- To consider your role in advising on medicines for the elderly

Ageing is a process of gradual and spontaneous change, resulting in maturation through childhood, puberty and young adulthood and then decline through middle and late age.

Senescence, a related term, refers to the process by which the capacity for cell division, growth and function is lost over time, ultimately leading to an incompatibility with life; that is, the process of senescence terminates in death.[1]

We are all aware of ageing. We see physical and cognitive changes in ourselves and those around us. Most changes are part of normal ageing, but some are the result of environmental and lifestyle factors. Disease may also interfere with the normal replacement of cells, resulting in an increased rate of ageing, sometimes of specific cells responsible for specialised functions.

Signs and symptoms of ageing include:

External appearance

- Height – decreases because of scoliosis (lateral curvature of the spine) or kyphosis (hump back), foot arches fall and intervertebral disks dry out.
- Hair – greying, thinning, possibly baldness.
- Skin – loss of collagen and elasticity, wrinkles, dehydration.
- Teeth – enamel yellows.
- Nails – thickening and plate elevation.

Body composition

- less muscle
- more fat, especially around the waist
- loss of intracellular water
- reduced bone density.

Mental capabilities

- variance with chronological age – 'second childhood'
- decreased ability to process information
- loss of short term memory and, later, long term memory.

Endocrine

- menopause and loss of sexual drive
- carbohydrate tolerance – onset of type 2 diabetes.

Physiological/biochemical

Although these changes are not usually observed directly, many are recognised by their effects on a person's activity. The effects on the heart, blood vessels and lung result in decreased ability for physical exertion and the extended time it takes to recover, for example, even the performance of trained athletes decreases with age: they peak and then decline. An elderly person takes longer to climb a flight of stairs and then 'get their breath back'.

Many of these changes directly affect the way the body absorbs, distributes, metabolises and excretes drugs, which is the definition of pharmacokinetics. Others modify bodily functions so that the effects of drugs are modified.

Cardiovascular

Decreased:

- cardiac output/stroke volume
- maximum heart rate
- vessel elasticity
- fibrin in walls
- peripheral perfusion
- organ blood flow

Increased:

- risk of blood coagulation
- recovery time to restore heart rate following exercise.

The elderly are more likely to take medicines than any other age group, taking an average 3.4 medicines at any one time

Decreased blood flow affects all body functions and should be carefully considered when thinking about the activity of any specific organ, especially the liver and kidneys.

Renal function

Decreased:

- glomerular filtration rate
- renal blood flow
- excretion and re-absorption
- bladder supporting elastic tissue.

Respiratory

Decreased:

- oxygen uptake
- ciliary activity
- dead lung space
- forced expiratory volume/ peak flow

Increased:

- rigidity of lung tissue.

Nerve/CNS

Decreased:

- nerve conduction velocity
- receptor sensitivity
- acuity of the senses (hearing, sight, taste, touch, smell)
- cerebral processing

Increased:

- reaction time
- movement time.

Muscle

Decreased:

- size/strength of muscle fibres
- number of fibres
- physical fitness.

Gastrointestinal

Decreased:

- acid secretion
- gastric emptying time (delayed)

Continued on page 22 ▶

- gut motility/peristalsis.

Endocrine
Decreased:
- glucose tolerance/ responsiveness to insulin
- thyroid activity
- adrenal activity
- sex hormones.

Disease/illness
- increased incidence of all diseases, particularly arthritis, osteoporosis, cardiovascular disease/hypertension, diabetes, cancer
- increased susceptibility to anxiety (which may affect decision-making abilities).

These changes primarily result in less efficient body functions and are significant in the way the body handles and responds to drugs.

Homoeostasis
Homoeostasis refers to the maintenance of relatively stable internal physiological conditions (respiration rate, heart rate, body temperature etc) under varying environmental conditions such as physical activity and changes in external temperature.

As people age it takes more time for the internal physiological processes to respond to any external change. There may be a number of reasons including a loss of receptor sensitivity (to temperature, pain, pressure etc), reduction in the compensating feedback mechanisms responsible for homoeostasis, and decreased organ response to such mechanisms. All these factors result in drugs having different quantitative effects in older compared with younger individuals.

Drug action

Drugs must be at their site of action in sufficient concentration (bioavailability) to cause the desired effect. This concentration is affected by pharmacokinetic factors, which differ in the elderly from the young adult. The main factors to consider for an orally presented drug include absorption, distribution, metabolism and elimination.

Absorption
Most drugs are administered orally and thus absorption from the gut provides the first barrier to the target organ. Changes affecting this process in the elderly include increased gastric pH, delayed gastric emptying and motility with decreased intestinal blood flow (hepatic-portal system). The drug absorption graph shows a changed shape with lower peaks and longer duration. But these changes are clinically insignificant in most cases so drug absorption tends to be similar in older and younger people.[2,3]

Distribution
Drug distribution is determined by many factors including:
- body composition
- plasma protein binding
- organ blood flow.

All these change with age so it is not surprising that drug distribution changes at the same time. This may result in different active drug levels (when compared with a similar dose in a younger person).

Body composition: body water decreases by 10 to 15 per cent (as a percentage of body weight) between ages 20 and 80 years, while the percentage of fat in the body increases from 18 to 36 per cent in men and from 33 to 45 per cent in women.

This affects drug distribution in that water-soluble drugs will reach a higher blood concentration for the same dose when compared with that of a younger person. Thus the normal adult dose of aminoglycosides (such as streptomycin) – which are polar (water soluble) – will produce a higher blood concentration in the elderly.

This phenomenon contrasts with lipid soluble drugs, such as phenytoin, diazepam and flurazepam, which have lower blood concentrations in the elderly compared with younger people for the same dose level.[4]

Plasma protein binding: many drugs are bound to proteins but the active moiety is the free drug: protein bound drugs are inactive. With age, serum albumin levels decrease (in the 80 year old 20 per cent less than in the 20 year old) and acid glycoprotein levels increase, but the clinical effect of these changes on serum drug binding is unclear and probably not clinically significant.[5,6]

However, in a patient with acute disease or malnutrition, rapid decreases in the serum albumin level may enhance drug effects. This is significant in patients taking warfarin where the serum concentration of unbound drug is increased and a new INR is probably advisable.

Organ blood flow: cardiac output decreases by about 1 per cent per year after the age of 20 years. This, in conjunction with other factors such as increased flow resistance, results in up to 45 per cent reduction in perfusion of the limbs, liver and mesentery compared with a 25 year old. Perfusion of the heart muscle is reduced by up to 30 per cent and that of the brain by up to 15 per cent.

Although little clinical evidence is available to support changes in drug distribution as a result, it is logical to assume decreased tissue perfusion and thus a decreased rate of drug distribution to tissue.

To summarise, drug distribution is affected by the normal physiological ageing process, which includes a higher percentage of fat to lean body mass, a decrease in total body water, and decreased plasma albumin.[7] This may result in the need to increase the dose of lipophilic drugs (taking into account their modified duration of action) while reducing the dose of water-soluble and protein bound drugs.

Metabolism

Most drugs are metabolised in the body; very few are excreted unchanged. These metabolic processes occur by means of enzymes, which are found throughout the body but are concentrated in the liver and, to some degree, in the kidneys and lungs.

A drug exerts its action either in its free form or as the active metabolite or a combination of both. The ageing process modifies the body's metabolic capacity. In oral drugs the main site of drug metabolism is the liver (first pass metabolism). Liver function, as measured by biochemical, microsomal and cytoplasmic parameters, does not significantly decline with age. In the elderly, however, both the liver mass and the blood flow through it are reduced by up to 40 per cent compared with in a 20 year old. The cytochrome P450 system also decreases by up to 40 per cent with ageing.

These changes result in a substantial reduction in the liver's ability to metabolise drugs. This may increase the effect of a drug that is usually metabolised to an inactive metabolite in the liver, while reducing the effect of a pro-drug (compared with a younger person). It should be noted that factors other than age, such as smoking, alcohol, caffeine and acute illness, might significantly influence metabolism.

Elimination

Unwanted substances are eliminated from the body through the kidneys, skin, lungs and the intestines. Drugs are eliminated unchanged, conjugated or as their metabolic derivatives. While the efficiency of all these channels changes with age, it is the age-related changes in the renal route that are most significant for most drugs.

With increasing age the size of the kidneys and renal blood flow decrease significantly, so that by the age of 80 years the total cortical mass is reduced by about 20 per cent compared with 20 years old.

These factors contribute to a progressive reduction of glomerular filtration rate (by up to 65 per cent compared with a 20

Box 1: Pharmacogenetics and individual response to drugs

Probably the most important factor affecting drug action is the way the drug is metabolised in the body. Work on pharmacogenetics suggests that genes control the specific enzyme systems present in each individual and that it is this specific 'mix' of enzymes which is responsible, at least in part, for individual variation in response to each drug.[1] However, once an enzyme 'mix' is established, age itself has little significant effect on drug action.

Box 2: Clinical implications

The **benzodiazepines** are metabolised in the liver. Orally administered diazepam (primarily inactive) is metabolised in the liver to the active drug nordiazepam. Being lipophilic, diazepam is stored in fat. On absorption the plasma level rapidly increases, then reduces as the drug is redistributed in fat. Hence there is an initial action of the benzodiazepine, but the effects wear off as the plasma level drops with the drug's uptake in the fatty tissues.

The half-life of diazepam in the young adult is long, but in the elderly it is increased to about 220 hours as a result of both reduced liver blood flow and enzyme activity. The half-life is much longer because there is slow release from the fat as the circulation is poorer than in the young, together with slower enzyme activity in the liver. Other benzodiazepines (lorazepam, temazepam) are not activated to such an extent by the liver and are therefore less affected by ageing.

Box 3: Dosage adjustments for drugs with a narrow therapeutic index

Drugs with narrow therapeutic indexes (for example, aminoglyeosides, digoxin, lithium, proeainamide and theophylline) require dosage adjustment in the elderly. Use of formulae (for example, the Cockcroft-Gault formula) to estimate creatinine clearance can be misleading in the elderly. The most accurate measurement of renal function is with a 24-hour urine creatinine elearanee assessment. To minimise risk of error, the peak and trough blood levels should be obtained after three to five half-life periods of doses, beeause bioavailability and other clearance mechanisms may alter dosing requirements that were determined by estimates of ereatinine clearance.

Table 1: Drugs that require extra care when prescribing for the elderly

Class	Reduced hepatic metabolism	Reduced renal elimination
Analgesics and non-steroidal anti-inflammatories	Dextropropoxyphene Morphine Ibuprofen Naproxen	
Antibiotics		Ciprofloxacin Gentamicin Nitrofurantoin Streptomycin Tobramycin
Cardiovascular	Amlodipine Diltiazem Lidocaine Nifedipine Propranolol Quinidine Verapamil	Captopril Digoxin Enalapril Lisinopril Procainamide Quinapril
Respiratory	Theophylline	
Diuretics		Amiloride Furosemide Hydrochlorthiazide Triamterene
Psychoactive	Alprazolam Chlordiazepoxide Citalopram Desipramine Imipramine Nortriptyline Trazodone Triazolam	Lithium
Anti-Parkinson's	Levodopa	Amantadine
Oral hypoglycemics		Chlorpropamide
Gastric tract		Cimetidine Ranitidine
Others	Fentanyl	Methotrexate

Table 2: Physiological changes in the elderly

Physiological parameter	Change		Significance
	Decreased	Increased	
Absorption	Salivary flow Gastric emptying time Absorption surface area Blood flow Motility	Gastric pH	Of little significance
Distribution	Lean body mass Total body water Serum albumin	Glycoprotein	Increased available level of water-soluble drugs. Increased fraction of protein bound drug
Metabolism	Hepatic capacity, mass and blood flow		Decreased first pass metabolism
Elimination	Renal blood flow and glomerular filtration rate		Decreased elimination of drugs and their metabolites

year old), reduced tubular secretion and declining renal function. For these reasons the *British National Formulary* assumes mild kidney impairment for the elderly: this impairment is frequently one of the major factors influencing altered drug levels in these patients.

Because renal function is dynamic, maintenance doses of drugs should be adjusted if a patient becomes acutely ill or dehydrated or has recently recovered from dehydration. Also, because renal function may continue to decline with age, the dose of drugs given long-term should be reviewed periodically.

Some of these effects on specific drugs are summarised in Tables 1 and 2. A schematic view of the location of free and bound drugs and their metabolites is shown in diagram 1.

Pharmacodynamics

In the elderly the number of target receptors is reduced and their sensitivity may be either decreased (beta-blockers) or increased (CNS drugs). These age-related changes in pharmacodynamics can result in greater therapeutic effect as well as an increased potential for toxicity.

Side actions of drugs differ markedly and are usually enhanced in the elderly. For example, high doses of a non-steroidal anti-inflammatory drug may cause an increase in blood pressure, which although modest, is beyond a critical threshold, prompting the initiation or intensification of antihypertensive therapy. Similarly treatment with amitriptyline, which has significant anticholinergic properties, may lead to constipation and chronic laxative therapy. It is essential to select appropriate drugs at their lowest dosage to avoid any iatrogenic problem. The prescriber and pharmacist should be aware that any new sign or symptom could be the adverse effect of the drug and reconsider its need.

Polypharmacy

The elderly are more likely to take medicines than any other age group.[8] It has been estimated that 85 per cent of people over 65 years old suffer from one or more chronic condition (compared with 40 per cent under this age). Elderly patients taking prescribed medicines receive an average of 3.4, so polypharmacy is rife.

It must be remembered when treating the elderly that drugs are not always the answer. Their reactions to drugs include agitation, falls, confusion, constipation, incontinence, memory deficits, dizziness and depression.

It is essential to identify correctly a cause/effect relationship between a problem and an iatrogenic effect of a drug. Incorrect identification may result in inappropriate discontinuation of drug(s) that may be of significant benefit.

It may also result in prescribing a second drug to reverse the side

Continued on page 24 ▶

Table 3: Drugs especially affected in the elderly

Analgesics	Opioids	Increased side effects – nausea, hypotension and CNS effects due to higher blood levels
	NSAIDs	May cause fluid retention. Gastric and renal effects
Digoxin		Reduced renal clearance
Diuretics	General	May cause hyponatraemia and postural hypotension
	Loop diuretics	Less effective, increase dose. Care with thiazides
H_2 antagonists		Reduced excretion, decrease dose (cimetidine)
Warfarin		Reduced enzymes in liver. Decrease starting dose
ACE inhibitors (beta blockers)		Less homoeostasis. More hypotension, more risk of renal impairment. Reduced/impaired clearance so higher levels especially atenolol, sotolol. Also fewer liver enzymes – propranolol level increased (for same dose)
Benzodiazepines		Deposit in tissue – longer half-life
Phenothiazines		Increased extrapyramidal symptoms, anticholingeric effects
Anti-Parkinson's		More pronounced side effects

effects of a newly prescribed drug. For example, a patient started on haloperidol may develop extrapyramidal side effects, which may be misdiagnosed as Parkinson's disease and the patient inappropriately prescribed anti-Parkinson medication.[9]

Drug-disease interactions are not uncommon. Drug distribution may be impaired by congestive heart failure. Bioavailability of a protein-bound drug may be enhanced to the point of toxicity in malnourished, hypo-albuminaemic patients. Drug half-life may be increased dramatically by chronic liver disease or advanced renal insufficiency.

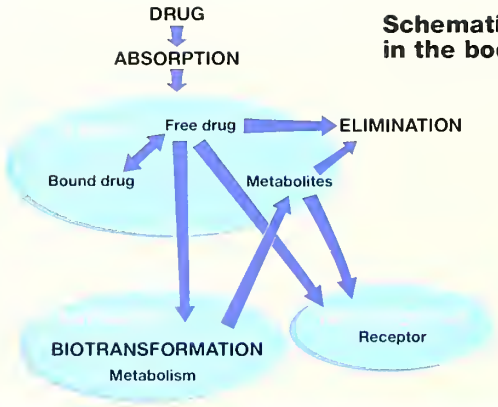
Ventricular arrhythmias may occur in patients with ischaemic heart disease who are receiving tricyclic antidepressants or phenothiazines. Orthostatic hypotension may be induced by many medications, including diuretics, alpha-adrenergic blockers, nitroglycerin preparations, phenothiazines, antipsychotics and antidepressants.

Multiple drugs, drug side effects, drug interactions, and drug-disease interactions contribute to the risks assumed when treating the elderly.

All healthcare professionals should carefully consider all these factors when supplying medicines for the elderly. The following list is a good starting point for thought.

Points of wisdom

1. Always carry out a drug review for all new patients. Make sure each drug is required and consider the potential iatrogenic effects.
2. Ensure that concordance is used as the basis of all drugs supplied.
3. Before introducing any new drug, review the patient's current medication.
4. Start low, go slow. Start all chronic medication at a reduced dose compared with the normal adult dose, especially psychotropics which should be introduced at as little as a quarter of the normal adult dose.
5. Avoid drugs with a long half-life when possible. Take particular care with the benzodiazepines.
6. Give the patient and/or the carer/family a written list of medications, the purpose of each drug, its strength/form and the dosing frequencies. Strive for once or twice daily dosing.
7. Encourage the reporting of any problems, especially those that could be drug-related.
8. Take advantage of drug side effects. For example, trazodone may be the ideal selection for a patient with hypertension, insomnia/anxiety, depression and chronic pain or neuropathy.
9. When a patient has new complaints, remember that drugs can cause illness.
10. Remember there is not a pill for every ill.



Schematic of drugs in the body

References available on request.

Derek Balon is a proprietor pharmacist and visiting lecturer at King's College London.

Actionplan

1. Make a table in your practice workbook with headings of "external appearance" and "observable body composition changes" that occur in old age. Record these characteristics for your next 50 elderly clients. How often can you see these markers of old age?
2. It might be interesting to do the same for 50 random clients. Are there significant differences?
3. Looking at the next 50 prescriptions for the elderly, can you see any signs that the normal adult dose is reduced? Record any you recognise. Is any particular drug or class of drug involved?
4. Read Appendix 3 of the *British National Formulary*: Renal impairment (text only; not the table). Revise the measurement of kidney efficiency.
5. In your practice workbook note prescriptions with more than four items. Record the class of drugs and whether the patient is elderly. What is the ratio between younger and older patients? Is polypharmacy more common for the elderly?
6. Select three drugs from Table 3. Record the next, say, 50 prescriptions for them for elderly people. Have the patients had any problems and has the GP asked them to report adverse effects? Has the doctor titrated the dose to suit the patient?
7. Record all hypnotics prescribed for the elderly. Assess how frequently they are prescribed. Is it too often? What should you do about it? (There will be a *Drug and Therapeutics Bulletin* article on this subject soon, so look out for it).

Distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, *C&D*'s readers can self-test their progress by using the multiple choice questions (MCQ) papers to be included in the September 4 issue, which will cover this week's CPP accredited articles, together with those in the August 7 and 14 issues. These will cover:

- **Vitamin A (1311)**
- **Ageing (1312)**
- **Lipids in diabetes (1313).**

To help pharmacists marking service offers independent verification of results – details on the monthly MCQ papers are available from the publisher for Pharmacy Update assessment act Mary Prebble on 01732 377269.

C&D in association with GP GENUS PHARMACEUTICALS

NRT helps men quit more than women...

Men do better than women, at least where giving up smoking with nicotine replacement therapy alone is concerned, researchers in the USA have said.

Men are more successful at smoking cessation with NRT than women, and the difference is most evident at the 12-month stage, a team of researchers from Texas A&M University has claimed. After three and six months, NRT was better than placebo with men and women achieving similar quit rates, found the researchers.

However, at 12-month follow-ups NRT worked better than placebo in men only, their meta-analysis of 21 randomised trials found.

Using non-drug support to change women's perceptions of the effect on weight and mood from smoking cessation could help prevent these women relapsing into smoking, said the researchers.

The efficacy of NRT diminished as the time it was used increased, but this was found to be statistically significant in women only at the six-month and 12-month stages. After 12 months, NRT was statistically superior to placebo in men but not in women. However, efficacy of NRT in women at the six-month stage improved if intensive non-pharmacological (behaviour therapy) support was involved. This support is intended to address the different variables that influence smoking in women, but do not affect men.

After 12 months, NRT was statistically superior to placebo in men but not in women with regards to quit rates

Previous researchers have suggested women find it harder to give up smoking because they experience more craving related to smoking cues, link smoking to improving mood or preventing weight gain, and enjoy the taste and hand-to-mouth sensations more than men. In comparison, men smoke to experience the psychoactive effects of nicotine, researchers claim.

For more information:

Journal of Consulting and Clinical Psychology 2004; 72: 712-22

... but NRT is a hit with teen smokers

Nicotine replacement patches help teenagers quit smoking, but staying off is harder for this age group compared to adults, US researchers have claimed.

The study compared use of NRT patches with and without bupropion for 211 teenagers (aged 15-18) who had already made a failed quit attempt. After 10 weeks, 28 per cent of the NRT-only group had quit compared to 23 per cent of the NRT and bupropion group. However, after 26 weeks this had fallen to 7 per cent and 8 per cent respectively. The teenagers also received counselling on behavioural skills to manage situations that triggered nicotine urges.

Despite the low success rate at 26 weeks, the authors are positive that the study provides evidence that NRT is a useful tool for teenagers who wish to stop smoking.

"Physicians used to believe that they didn't have the appropriate skills to help teens stop smoking," says lead author Joel Killen. "NRT may be a valuable tool for these doctors. This finding gives us a platform to build on."

Amanda Sandford, research manager at ASH, welcomed the research: "This study is important because it shows that, given the right support, adolescents are just as likely as adults to successfully quit smoking."

For more information:

Journal of Consulting and Clinical Psychology 2004; 72: 729-35

Pro-Banthine shortage

Hansam HealthCare has announced there is a short-term supply problem with Pro-Banthine Tablets 15mg (propantheline bromide).

Limited emergency stocks are available through Hansam (tel: 0870 241 3019). New supplies are expected early in September.

Fluoxetine and therapy are best

Teenagers with major depressive disorder respond better to fluoxetine in conjunction with cognitive behavioural therapy (CBT), US researchers found.

In addition, the combination therapy reduced clinically significant suicidal thinking in adolescents, whereas fluoxetine alone increased the number of harm-related adverse events, but not suicidal thoughts.

The study looked at 439 volunteers between the ages of 12 and 17 who were randomised to: 12 weeks of fluoxetine (10-40mg/day); CBT alone; CBT and fluoxetine (10-40mg/day); or placebo (equivalent to 10-40mg/day).

Patients receiving CBT and fluoxetine achieved a 71 per cent rate of response, fluoxetine alone 61 per cent, CBT alone 43 per cent and placebo 35 per cent. Seven (1.6 per cent) of the patients attempted suicide, but none died.

For more information:

JAMA 2004; 292: 807-20

Scriptlines

Denzapine tablets

Denfleet has launched Denzapine (clozapine) tablets at the same list price as branded clozapine, but discounts of up to 50 per cent are available.

The tablets are available in 25mg and 100mg doses, and Denzapine is indicated for treatment-resistant schizophrenia.

Patients are enrolled in the Denfleet Clozapine Monitoring Service for compulsory blood tests to detect agranulocytosis, which can occur in some patients. Bottles of 100 tablets will be available from September.

Price: 25mg x 28, £12.33; 25mg x 84, £36.97; 100mg x 28, £49.28; 100mg x 84, £147.84

Denfleet
Tel: 020 8236 0000

Juvela gluten-free lasagne

SHS International has launched Juvela gluten-free lasagne, which is available on prescription.

The product comes in 250g packs containing two cellophane wrapped packs of lasagne.

Price: £3.64 retail

Pack size: 250g
SHS International
Tel: 0151 228 8161

Generic mirtazapine

The first generic versions of mirtazapine 30mg tablets in packs of 28 for depressive illness are now being launched.

PIP codes:

IVAX Pharmaceuticals UK 111-6045; Alpharma 111-5575; Hillcross Pharmaceuticals 111-6854; and Focus Pharmaceuticals 111-6862.

Halls soothes sore throats with triple action

Cadbury Trebor Bassett will expand its Halls medicated confectionery brand with GSL licensed triple action sore throat lozenges on September 6.

Halls Soothers Triple Action lozenges contain hexylresorcinol and are designed to offer a more serious functional solution than the existing Halls Soothers.

The triple action lozenges are formulated to fight pain and infection and soothe the irritation of sore throats.

The new lozenges come in two flavours – original and honey and lemon.

The Halls brand will be supported by a £2.5 million marketing campaign including TV and direct mail activity.

Price: £2.25

Pack size: 20 lozenges
Ernest Jackson & Co Ltd
Tel: 01363 636100

Crampex won't cramp your style

Thornton & Ross is relaunching its pharmacy-only tablets for the treatment and prevention of cramp.

Crampex has an eye-catching new pack and features a knotted rope to convey the pain of night-time cramp. The tablets contain calcium gluconate, cholecalciferol and nicotinic acid.

The new pack carries the statement "for muscle cramp at night". A new customer leaflet entitled 'Don't cramp your style – a quick guide to muscle cramp' includes hints about coping with cramp.

The brand will be supported by a £250,000 national press campaign from August until the end of the year.

Price: 24 tablets £3.99, 48 tablets £5.99

Pip code: 24 tablets 042-3863
48 tablets 042-4226
Thornton & Ross
Tel: 01484 848200

Pharmacy focus for Canesten campaign

Bayer Consumer will back its Canesten Duo thrush treatment with a national TV campaign from August 30 until October 24.

First shown last May/June, the commercial opens with a woman entering a pharmacy.

She asks the pharmacist for Canesten Duo, takes the product with a sip of water and gets on with her day, highlighting the convenience of an oral treatment.

Targeted at women aged 18-44, the campaign is part of a total £5 million spend on TV advertising for Canesten this year.

Bayer says its objective is to highlight the role played by pharmacists and drive consumers into the pharmacy to ask for Canesten Duo.

An educational package and point of sale material is available for pharmacies.

For more information:

Laser Healthcare
Tel: 01202 780558

Soft & Chewy for adults too

Ernest Jackson is introducing a new look for its Bassett's Soft & Chewy Vitamins range.

The brightly coloured fruity pack designs have been created to add a more adult feel to the vitamin and multivitamin range.

The manufacturers aim to extend use of the range among the family as well as attracting more adult users.

The brand will be supported by a new national TV campaign and women's press advertising from the end of August until mid-October.

For more information:

Ernest Jackson & Co Ltd
Tel: 01363 636100

Strepils Extra grows with citrus menthol

Crookes Healthcare is adding citrus menthol flavoured lozenges to its Strepsils Extra range.

Strepsils Extra Citrus Menthol lozenges contain hexylresorcinol which has a local anaesthetic action to bring relief from painful, inflamed sore throats.

In addition, Strepsils Orange with Vitamin C has an improved flavour to give it a more pleasant orange taste.

Pocket packs of Strepsils (rsp £0.81, £0.98) have been redesigned to make them more compact and easier to open and reseal. The pocket packs come in a multi-purpose display outer that can be merchandised vertically or horizontally.

Price: Strepsils Extra Citrus Menthol £2.62

Pack size: 24 lozenges
Pip code: 306-6248
Crookes Healthcare Ltd
Tel: 0115 953 9922

Sensitive toothpaste now aimed at the smoker

E C De Witt is launching a sensitive version of its Clinomyn toothpaste for smokers.

Clinomyn Smokers Sensitive is a deep cleaning toothpaste for people with sensitive teeth and gums.

The toothpaste is formulated to gently remove nicotine, tobacco and food stains while helping to protect sensitive teeth and gums.

It contains fluoride to help strengthen teeth and protect against decay.

The product has a fresh mint flavour and is suitable for everyday use.

Price: £2.29

Pack size: 75ml
Pip code: 309-2038
EC De Witt & Co Ltd
Tel: 01928 579029

Olay has an eye for beauty

Procter & Gamble is launching two products for the eye area into its Olay skincare range on September 1.

Total Effects 7x Eye Transforming Cream with Vitaniacin is a rich eye cream formulated for women who are concerned about the primary signs of eye ageing – dullness, fine lines, uneven texture and puffiness.

The cream contains a blend of seven vitamins and minerals, cucumber extract and aloe vera. It also includes light diffusing powders to provide an instant glow to skin around the eyes.

Regenerist Eye Lighting Serum with Amino Peptide Complex is formulated for the more advanced signs of ageing around the eyes including loss of firmness.

The serum is claimed to firm eyelids, smooth out fine lines and wrinkles and instantly brighten the under-eyes.

Price: cream £14.99, serum £19.50

Pack size: 15ml
Pip code: cream 306-2403, serum 306-2395
Procter & Gamble UK
Tel: 01932 896000

Clean sweep for all skin types, without soap

Procter & Gamble will launch an Olay body wash and bath foam range for different skin types on September 1.

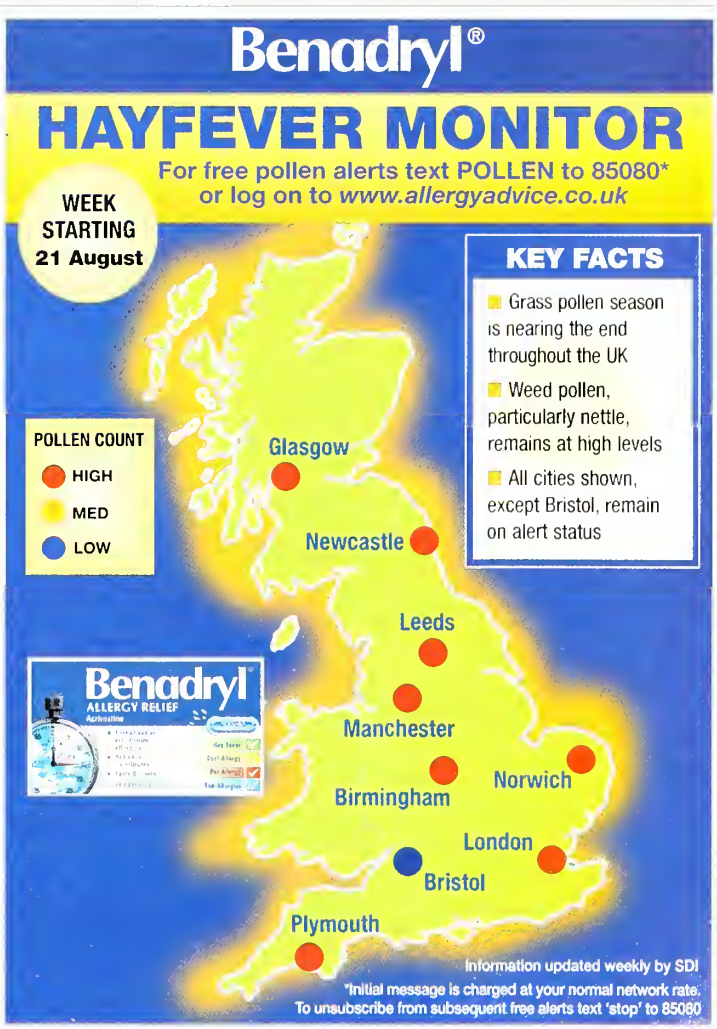
Olay Moisturising Body Wash comes in four specific skin type formulations for showering – Deep Moisture for Dry Skin, Intensive Moisture for Extra Dry Skin, Clean Moisture for Normal Skin and Gentle Moisture for Sensitive Skin.

Each soap-free body wash contains a combination of Olay moisturisers to leave the skin feeling soft and smooth. The body wash variants also include vitamins A, E and B_3 to nourish the skin.

Olay Moisturising Bath Foam, which also contains Olay moisturisers, is available in three variants – Nourishing for Dry skin, Soothing for Sensitive Skin and Softening for Normal Skin.

Price: £3.49

Pack size: Bath Foam 500ml, Body Wash 350ml
Procter & Gamble UK
Tel: 01932 896000



Frontshop

Syndol returns to TV

Syndol will be back on national TV in mid September supported by a £1 million advertising campaign.

The campaign will again feature the brand's commercial showing the humorous story of a male office worker with a headache.

The advertising will be on air from September 13 until October 3.

A range of point of sale material to reinforce the TV campaign is available for pharmacies.

For more information:
SSL International
Tel: 0161 654 3003

New term for Full Marks

SSL International is backing its Full Marks head lice treatment with a £1 million national TV campaign timed to coincide with the start of the new school term.

On air until September 12, the campaign will appear on ITV, GMTV, five and satellite. The commercial highlights the quick and easy application of Full Marks Mousse. The campaign is targeted at families with children aged from four to 10 years.

For more information:
SSL International
Tel: 0161 654 3003

Hot lips from Blistex

Dendron is launching a Blistexlip product formulated to give a glossy, wet-look finish that is non-sticky.

Blistex Satin & Gloss has a vanilla flavour and is presented in an easy-to-apply slimline stick.

The product is enriched with moisturisers including rose hip oil, aloe vera and vitamin E.

It also protects the lips from the sun with SPF6.

Price: £2.69
Dendron Ltd
Tel: 01923 229251

TV next week

Bisodol: Sat
Bodyform: C4, five, GMTV, Sat
Califig: C4, Sat
Full Marks Mousse: All areas
Germoloids HC Spray: C4
Imodium Plus Caplets: All areas
Just for Men: All areas
Kool 'n' Soothe Migraine: All areas except U, C4, five
Lamisil: All areas
Listerine: All areas except U, GMTV
Seabond: All areas
Simple Oil Control: five

PharmaSite for next week: Calprofen – window, **Fluconazole Care Range** – in-store, **Calprofen** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, Five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Sporting chance for adidas

Coty is introducing a new look for its adidas men's eau de toilette which now has stronger adidas branding.

The new clear glass eau de toilette bottle features a silver metal cap engraved with the adidas 3-Stripes trademark. The 3-Stripes also run up one side of the bottle.

The range comprises five fresh fragrances – Ice Dive, Urban Spice, Dynamic Pulse, Game Spirit and Sport Fever. All the variants are now formulated to be more resistant to washing off, intense physical exercise and perspiration.

Vibrant new colour coding is designed to improve differentiation between the fragrance variants and convey the association with sport.

Price: £5.95
Pack size: 50ml
Coty (UK) Ltd
Tel: 020 8971 1300

Omeprazole mix up

Our apologies to Thornton & Ross and AAH Pharmaceuticals for transposing the photos of Care Heartburn Relief 10mg Tablets (below) and Vantage Heartburn Relief 10mg Tablets (above) in last week's issue of *C&D* (p25).

First with Pravastatin

10mg, 20mg and 40mg strengths now available from *IVAX first*

Dispense our NEW Pravastatin Tablets for instant price benefits

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0mg, 20mg and 40mg presentations of 28 tablets
our highly acclaimed IVAX patient pack livery,
ill deliver excellent value for you and consistent
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imply phone your regular wholesaler, or place an
rder via your pharmacy terminal using the IVAX
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4

Trading

Sole trader, partnership

This is the fourth of a series of 10 monthly articles by Anne Hutchings, and sponsored by Nucare, which will be published in book format next year

The cost and administrative issues to consider if you are starting a new business or changing the way you trade now

Sarah Kranz

If you are starting out in business, for example buying your first pharmacy, the usual trading structures, which you are likely to come across, are:

- sole trader
- partnership, and
- limited company.

If you are already trading you may wish to consider changing from one trading format to another. Some of the issues to consider are administration, cost, limited liability, tax and exit planning.

Sole trader

This is the easiest format to set up. Basically you are the owner of the business, with control over the way in which it operates. For tax purposes you will be self-employed.

Administration: the admin involved in setting up as a sole trader is fairly minimal. The essentials are:

- open a business bank account
- inform the Inland Revenue of your business; there is a three month time limit for doing this or you will be fined £100
- register for VAT if applicable, for example if you are acquiring a retail outlet
- set up a PAYE scheme if you are employing staff
- set up a book keeping system and produce annual accounts.

Cost: the cost of setting up as a sole trader should be small and will depend on whether you decide to appoint an accountant to guide you through the initial start-up requirements or whether you decide to do it all yourself.

Liabilities: as a sole trader you will be personally liable for all the debts of the business.

Tax: tax will be based on the annual accounts and the net profit after business expenses and personal allowances will be taxed under self-assessment. The tax bands for the tax year ending on April5, 2005 are:

Income up to £2,020:	10%
The next £29,380:	22%
Over £31,400:	40%

In addition, national insurance contributions will be payable each year at the flat rate of £2.05 per week plus 8 per cent of profit between £4,745 and £31,720 and 1 per cent of profit over £31,720.

As an indication of the amount of tax and national insurance which would be payable as a sole trader I have produced the following examples:

Taxable profit	Tax & NI
£40,000	£10,555
£60,000	£18,755
£80,000	£26,955
£100,000	£35,155

Exit planning: trading as a sole trader can be cost effective when it comes to selling the business. This is because individuals are entitled to business taper relief, which substantially reduces their capital gains tax.

Mr Robson sells the goodwill in his pharmacy for £500,000. He originally started the business from scratch 10 years ago, his capital gains tax bill will be approximately:

Sale proceeds	£500,000
Less business taper relief (75%)	375,000
Net gains	£125,000
Less annual exemption	£8,200
Taxable gains	£116,800
Tax at say 40%	£46,720

Partnerships

This trading format is similar to the sole trader set up but instead of trading on your own you have one or more business partners. You will be self-employed for tax purposes and taxed on your respective share of the profits.

Administration: the admin is similar to that for a sole trader. However, in addition partnerships should have a partnership agreement.

The issues covered in a partnership agreement will be items such as partner's role/duties, sickness, future exit procedure, etc.

Cost: the cost will be similar to a sole trader plus the cost of taking advice on partnership issues.

Liabilities: as a partner you will be jointly and severally liable for the debts of the partnership, even if it was your business partner who incurred the liability.

formats

or limited company?

Tax: each partner will be taxed under self-assessment on his or her respective share of the taxable business profits.
Exit planning: again partnerships are similar to sole traders when it comes to selling the business assets. Business taper relief can be claimed by the individual partners against their respective gains.

Limited company

A limited company is a separate legal entity and as such it is more complicated to set up and to administer.
Administration: to trade through a company will involve the following:
Obtaining a limited company: this can be done through a company formation agent, where you can either purchase a ready made company or have one formed with a name of your choice (subject to certain restrictions).

- Deciding who will be company director(s) and company secretary.
- Deciding who the shareholders will be. They can be non-pharmacists, which gives more flexibility than a partnership structure where each partner should be a pharmacist.
- The other company admin is similar to that for sole traders and partnerships. However, in addition company shareholders (particularly if they are unrelated) should have a shareholders agreement.

Cost: to set up a limited company or buy a ready-made company will cost around £100. However, you should take advice from a tax adviser or accountant regarding the shareholdings, appointment of directors etc and from a solicitor regarding shareholders' agreements for which you will be charged a fee.

Also allow for fees for registering the business for VAT, payroll, providing company details for the Inland Revenue and setting up the book keeping system.

Advisers' fees will vary so you should agree a set fee at the outset so that you can budget for this.
Liabilities: your liability should theoretically be limited to the amount invested in the company. However, banks and other lending sources often want personal guarantees from the directors.
Tax: companies pay corporation tax on profits after deducting business expenses. The corporation tax rates for the year commencing on April 1, 2004 are as follows:

First £10,000	Nil
Next £40,000	23.75%
Next £250,000	19%
Next £1.2m	32.75%
Over £1.5m	30%

Company capital gains are also taxed at corporation tax rates.

The following table shows a few examples of the tax a company will pay (ignoring at this stage payments to the business owners/directors):

Company taxable profit	Corporation tax
£10,000	Nil
£30,000	£4,750
£50,000	£9,500
£70,000	£13,300
£90,000	£17,100

Exit planning: generally the owners should aim to sell the company rather than the assets in the company. The reason for this is that the shareholders should usually qualify for business asset taper relief on the disposal of the shares, reducing the effective tax rate to 10 per cent.

There are exceptions to this guideline so it is always important to take proper professional advice. If the company sells the goodwill it will pay tax on the proceeds (less original cost, allowable expenses and an indexation allowance).

At this point the proceeds will belong to the company and if the owners wish to take the money out of the company for their own purposes they will be liable for further tax.

Alan runs his pharmacy through a limited company and decides to sell the business and has agreed a price of £500,000 plus SAV.

The contract was started from scratch so no acquisition costs are applicable and for the purposes of this illustration we are ignoring any allowable expenses. Alan's options are:

1. For the company to sell the goodwill, fixtures and fittings and stock.
2. For Alan to sell the company.
For option 1: the company has a gain of £500,000 on which the corporation tax is say £136,000. This leaves a net sum in the company of £364,000.

If Alan finds he wants to extract this money from the company he may be able to wind the company up and treat the distribution as a capital sum on which capital gains tax is payable. In which case his additional tax liability at say 10 per cent would be around £36,400 (ignoring the annual exemption).

Therefore, the overall tax payable under this scenario is in the region of £172,400.
For option 2: Alan sells his company shares and faces a capital gains tax bill of approximately 10 per cent which would be £50,000.

When comparing both options there is a substantial tax saving by taking the route of option 2.

So having looked at the three main trading methods, which is likely to be the most suitable for pharmacists? There is no question that substantial amounts of tax can still be saved by trading through a limited company.

Overall, I believe it is a case of looking at each individual case, examining all the circumstances and balancing this against the estimated tax savings and the pharmacist's longer term plans.

Watching you Watching me

In January 2000, we reported on the sociological research that pharmacist Malcolm E Brown carried out in community pharmacy. With the benefit of time he reflects on what 'really happened'

My eyeballs bulged in amazement. I had to put pennies into tills. I had to, personally, dispense prescriptions and do so, not in order of presentation or clinical need, but the degree of commotion that the patient would cause if kept waiting.

It was astonishing to an ex-hospital pharmacist working for the first time in the community. I needed to earn my bread there after redundancy from my hospital post. I left the big, district general hospital for the little, corner shop. My 34 staff were reduced to one. Patients became customers. I interacted with unqualified assistants instead of consultant physicians. Clients' grave diseases changed to minor symptoms. Signs proclaimed not 'Pathology' but 'Three for the price of two'.

Sitting on committees, riven with political factions, changed to advising individual, anxious clients who had asked for, and wanted to listen to, my advice. But my warm, centrally overheated office was exchanged for a chilly back room. There, the only heating was a bottled-gas fire – and I had to go out in the pouring rain to buy a box of matches. These are extreme comparisons but illustrate my sense of alienation. Moreover, I had chosen to add to my stress. I was recording my interactions with customers, pharmacists, staff, doctors, everything, such as the smell of perfume, and doing so covertly.

Had those hiring me realised I was doing that, they might not have offered me more work as a locum. Was observation ethical? Results might damage groups like pharmacists. I was an apprentice sociologist starting to collect data for a PhD.[1]

My 'role model' was the proverbial Martian who found everything that earthlings did was strange. I worried that results might upset pharmacists or, worse still, baffle them.

Such ethnographic study demanded immersion in a strange culture for at least a year. Anthropologists had been reporting strange societies and telling their tales for generations. Few anthropologists leave their fields unscathed. I did not realise that when I started my ethnographic study. It was not in far away places but nearby, in British community pharmacies. There I discovered the strange world of the community pharmacist and it was such a shock that it hurt.

So anxiety heaped upon anxiety. It led to a level of stress that I had seldom previously experienced. I was shaken, frothed up.

Because I could not openly record notes as events occurred, I jotted down the odd word on paper scraps such as prescription bags and pocketed them. Then,

Continued on page 34 ▶

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to deliver ™ over a larger nd provide added ction to the d, these pent dressings ade to stop ng from cuts, es and surface ds fast.

SEAL-ON™ Plasters

Ideal for scrapes, grazes, scratches, cuts and abrasions where there is visible bleeding. These plasters feature absorbent pads impregnated with m•doc™ which stops the bleeding fast. The pads of the plasters have a non-stick layer to ensure they do not stick to the wound, which helps to further reduce the risk of renewed bleeding.

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m•doc™ impregnated non-adhesive patches stop bleeding fast from cuts, scrapes and surface wounds on larger areas. SEAL-ON™ patches have a non-stick layer to ensure that they do not stick to the wound, which reduces the risk of renewed bleeding. Patches can be cut or shaped to fit awkward areas, or folded for extra cushioning.

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during my lunch hour or that evening, I extended those words to fuller notes. Occasionally, something occurred so illuminating that fuller notes were immediately required. I wrote them in the lavatory, developing a severe case of 'ethnographer's bladder'.

I recorded my most striking perceptions; subjectivity is cherished in (qualitative) ethnography. Routinely, to check that the fieldworker's opinion is not idiosyncratic, the account is triangulated against data collected through other channels such as focus groups and interviewees with full informed consent. Opinion should match. Then, a story about the meaning of the natives' world is presented to the natives for comment. Results were published in a paper in the *International Journal of Pharmacy Practice*.[2]

Briefly, from one perspective, pharmacists can be seen as actors on a stage. Their stage is a community pharmacy. Pharmacists identify strongly with that stage. There are stage props such as their registration certificate, green cross, computer and – above all – their actual medicines. Pharmacists act the part of converting drugs into medicines, personalised for specific patients. Their performance is complex and well rehearsed. There are sometimes distractions that impede their performance. For example, the gargantuan, mechanical heckler of the tannoy in a grocery superstore that bellowed: "Fresh Galia melons: half price!"

Pharmacists must manage their stress, such as when busy or being expected to manage without a lunch break. Professional practice is based upon trust and when their performance falters they appear less than completely competent and that trust may fail. That is not a trivial matter.

My warm, centrally overheated office was exchanged for a chilly back room

To write that account had complications. For example, I had to discard data supporting a hypothesis because data might identify individuals; natural science researchers seldom have moral obligations towards test tubes. Absolute confidentiality about patient details was of course maintained.

A decade has passed since my fieldwork permitting sensitivities to cool. I can, now, report to you, the natives studied, what went wrong to make it easier for subsequent researchers; my research was the first 'proper' ethnography of British community pharmacy.

I learned most when I was most naive, in the first three weeks. Impressions flooded in so fast that I probably missed much. I would probably have captured more had I known a thing or two about what to do. First, I should have practised in an ethnographic-style study (say about six weeks) in another field; second, I should avoid emphasis on quantitative approaches. This may perturb pharmacists who are natural scientists. They believe that quantification is important: the best way of achieving objectivity. In quantitative research, you (already) know what you want; in qualitative research you want to know. Once you have chosen what to look for – and then count – blinkers tend to stop you seeing anything else. So concentrating on analysing computer printouts privileging the results of statistical tests may well prove barren. They rely on the wrong part of the brain, the deductive, focus-down-to-a-point, left hand side. You need to nurture your inductive, open-out-wide, right hand side.

Third, I should have expected to rewrite my account numerous times as new insights emerged. This is, after all, *re*search: you search again and again, then ferret at the bewildering, jumbled, exciting heap of data until you find its unifying theme. My eureka moment occurred while pondering over a field note written four years previously. "You're with the

This is, after all, *research*: you search again and again, then ferret at the bewildering, jumbled, exciting heap of data until you find its unifying theme

harmaceuticals," a cleaner had said before I addressed an RPSGB istriet branch meeting: not 'pharmacists' but 'pharmaceuticals', the nedieines, the physical artefacts. Those artefacts underpin the harmaeists' world. Without them, the pharmacists' world, as we know , would disappear. For example, pharmaey technicians might dispense rescriptions in factories. Technicians would only resort to calling in a assing (expensive) pharmacist when unavoidable, just as you only urchase a replacement silencer for your car when forced to.

Fourth, you should seek as much help as you can get from experienced thnographers. Ethnography is not telling a story with attention rabbing headlines, telling it like a journalist. Ethnography is getting aside the skins and minds of the natives. It comprises understanding neir world from their point of view, interpreting it, telling it like an thnographer. My ethnographie research ploughed a furrow at the eriphery of pharmaey but was midfield for anthropologists and sociologists. That realisation humbled me.

Finally, brace yourself for possible, emotional distress while in the field and by your exit. Ethnographers generally leave their fields when they are learning little new. Suddenly you stop synthesising, analysing, pondering "Why?" I have become just another jobbing locum, proud be a community pharmacist, trying to give customers what they wanted. However, I, and my world, had ehanged yet again – a dizzying, rollercoaster ride.

My days as an ethnographer to community pharmacy are over; I have 'gone native' and so am blind to new insights. However, before that occurred, I did demonstrate that pharmaeists can do 'proper' ethnography. I hope that others will follow.

If I can do it, so can you; I urge you to do so. Shoek is the ethnographer's stoek in trade. It enables them to see. So pharmacists practising in hospitals or industry, or existing community pharmacists such as proprietors starting to practise in another location such as superstores, could see most clearly.

My study was just the proverbial, tiny stone placed on top of a cairn on a mountain. Other studies to support or contradiet mine are needed. For example, my hunch is that pharmaeists, scrutinising their second by second praetiee, would report a higher error rate when extremely busy; that matters.

Opportunities for ethnographie research exist now. Ethnographic esearch may be harrowing. However, ethnography concerns actual ractiee about pharmacists in contact with patients; you may consider hat more pertinent than laboratory research. I suggest the benefits of thnography may be enormous. It is a largely unexplored territory waiting discovery; community pharmacists practising at the counter ace could be the explorers.

One area may be partieularly produetive. Dependent prescribing pharmaeists should report their praetice. So should the first ndependent prescribing pharmaeist. The pereeptions of that individual annot be hampered by talking to a predeeessor. For example, will that railblazer be like us: the herd of 'ordinary' pharmaeists, or a medical practitioner?

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Ask a **busy** man

Ash Soni, the new NPA chairman, has a tough year ahead as he looks to balance a new contract with possible deregulation, reports Gary Paragpuri

On his appointment as chairman, the NPA described Ash Soni as a "cutting edge practitioner", and if you were to thumb through his CV you would see why.

At a time when many pharmacy proprietors struggle to cope with an ever-increasing workload, Mr Soni manages to combine his day job of pharmacy contractor with three positions at his PCT, one at his LPC, and a further one at the All-Party Pharmacy Group. And he will certainly need all this experience during his term of office at the NPA, as the Government continues its wide-ranging reform of primary care health services.

He has singled out four priorities that he is keen to address during his tenure – the implementation of the new pharmacy contract, the roll out of supplementary prescribing, the development of a pharmacy public health role, and a more strategic role for the NPA board.

Mr Soni believes the NPA has a vital role to play in ensuring the success of the new contract. Although PSNC is responsible for negotiating the contract's framework and funding, it is the NPA that is charged with delivering the toolkit to help contractors implement it.

With the contract framework agreed, PSNC and the DoH have moved onto discussing funding, as contractors wait to see if the Government keeps its promise of paying contractors a fair wage. PSNC has been tight-lipped over the details, but did dismiss the first pay offer as "wholly unrealistic". And, judging by PSNC's reaction, the second offer also looks unacceptable.

Mr Soni's take on this is that in presenting a poor opening position, the Government appears to have failed to recognise the need for the number of new services in the new contract that have to be funded.

Nor has he ruled out the fact that the DoH might be using delaying tactics to give PCTs time to get to grips with the new GMS and consultant contracts. Whatever the reasons for the delay, he doesn't think there will be an implementation: "I genuinely believe that'll be very difficult for the Government to do and it [would] mobilise pharmacy in a way which would put the OFT campaign to shame."

There is no doubt the contract will happen. Both the Government and the profession accept that a new patient-focused contract is a no-brainer, as the current contract offers no incentive to develop services. However, once the contract is in place, further issues will need to be addressed. Who, for example, will help pharmacists negotiate with PCTs to ensure they are paid a fair rate for locally commissioned services?

"Technically it has to be LPCs because they are the recognised bodies that represent community pharmacy within the PCT but one of the roles of the NPA and PSNC is going to be about helping LPCs in those negotiations.

"We can say 'they've done that, for example, in Exmouth, this is how they did it, this is what their contract says, and this is what they've negotiated'.

"Why should the PCT rewrite the service specification?" he asks, saying there are plenty of existing good examples to act as templates.

The difficulty however will be in ensuring information is shared nationally, and pharmacy organisations will have to make sure their databases are improved because, if they aren't, there will be a danger of postcode pharmacy services developing, he agrees.

Why spend millions of pounds on building the same model again – it just seems absolutely crazy

And underpinning the new roles will have to be a robust IT infrastructure. He is so certain IT is crucial to pharmacy's future that he has been quick to voice his concerns. "Every time I see Rosie Winterton, she says 'you're allowed to say one thing to me' and I have to admit I always say 'IT' because without it the system will not work."

He points out that, while the decision-makers argue over the level of access pharmacists will get to medical records, patients' views must not be overlooked.

"If we give patients the choice, which is what we're supposed to be doing, then in a lot of cases they would be happy for us to access quite high levels of information because it would make our treatment of their health much better."

But a new contract is not all that is on the horizon, as the Government looks set on a degree of deregulation to the community pharmacy network. Although the decision to let the DoH rather than the DTI lead the Government's response represents some good news, contractors remain in the dark about the final outcome.

Mr Soni however believes deregulation will create problems for PCTs because they will still need to manage healthcare. A solution could be for PCTs to give new pharmacies dispensing-only contracts. If they want to provide other services (and get paid for them), they would have to demonstrate a need for them. But the control of entry changes must be carried out in conjunction with the new contract, he warns.

An issue close to Mr Soni's heart is pharmacist prescribing. As one of the first to qualify as a supplementary prescriber – although yet to issue his first prescription – he is adamant pharmacists can deliver real health benefits.

"There's got to be a huge benefit if such a large percentage of GP consultations are for

We represent all owners and we're damned good at it. We cater across the whole sector; you've got to remember, I'm chairman and I've only got one shop

minor ailments or repeat prescriptions. Why are they being done in surgeries and what is the added value the doctor is providing under those circumstances? Surely the added value would be greater from a pharmacist who understands the drugs taken by the patient."

He feels just as strongly about pharmacy's public health role. "Pharmacy is the walk-in centre. Why spend millions of pounds on building the same model again – it just seems absolutely crazy."

The NPA, along with PSNC, the RPSGB and PharmacyHealthLink, has won a Government tender to develop a pharmacy public health model. Although some argue the model should have been developed as part of the framework for the new pharmacy contract, Mr Soni doesn't place too much importance on this. In fact, he believes the delay could prove to be a bonus.

"If they want us to provide public health now, and because the [contract's] framework is already agreed, it will theoretically have to be funded as a new service."

However, if pharmacists are to take up these new roles, then delegating the dispensing process to technicians is the way forward but not at pharmacists' expense, Mr Soni argues. "I don't enjoy lick and stick and I have no problem with the technician doing that side of the role, but what I am saying is that you'll still need – and the patient will still want – the option of talking to a pharmacist."

The danger of delegating dispensing to technicians is it could lead to pharmacists leaving the premises and "that's when the system starts to fall down".

Apart from all the external issues, Mr Soni also faces challenges closer to home. He believes the NPA board has got bogged down with the huge amount of paper emanating from organisations and wants the subcommittees to take up the slack and allow the board to develop more of a "strategic overview".

The continued rise of the multiples also creates problems for the NPA. As more pharmacies are owned by a smaller number of players, the NPA faces a reduction in the actual number of members, even though the overall size of its membership base remains the same. Mr Soni recognises this and says it is key that the NPA remains financially viable to allow it to develop new services.

Further, with a handful of members representing a significant proportion of its membership, Mr Soni is keen to allay fears that the independents' voice will not be heard. "I've read various criticisms about us becoming more multiple orientated: I don't think we are. We represent all owners and we're damned good at it. We cater across the whole sector; you've got to remember, I'm chairman and I've only got one shop."

But with the NPA's recent decision to allow Asda to join as well as those pharmacies that have doctors as major shareholders – an issue that prompted the resignation of former NPA chairman Terry Hannawin from the board – what assurances can the NPA give to the independent sector that its views will not be ignored?

Mr Soni argues that the latest policy just reinforces what the NPA has been doing for some time. "This has suddenly become a really big issue about the multiples, but looking at it historically we've had all the big multiples [except Boots] as members for years," he says.

"What is significantly different to what we have done already?" This is not a major sea change in the outlook of the NPA, but he is concerned that some people have suddenly started to perceive it as such.

On Mr Hannawin, he says: "I think that what he thought we were doing and what we've actually done are two very different things. We have never and never will represent dispensing doctors: that is a firm commitment and it will be over my dead body if that happens."

Asda's acceptance into the fold did however raise a few eyebrows. After all, it contributed to the demise of RPM and its position on control of entry is at odds with the NPA's. Can the NPA give a cast iron guarantee that it will continue to represent the independents that have been the backbone of the association over the years?

"Asda has a position, the NPA has a position, we've got a mix between the two and I'm sure some people will be happy with that and some won't.

"Yes there are always going to be disagreements and challenges but I think there are things Asda can gain from us and I think Asda's perception of pharmacy is slightly different to what it used to be," he argues.

"Asda has made a big thing about [deregulation], but if there are other NPA members who would probably like deregulation, what's different between them and Asda? I can't see it and if you look at the CCA, which represents all the big guys, it never took a position on OFT because there were strong disagreements internally.

"The NPA will continue to look after the best interests of community pharmacy, which may be different to the best interests of Asda, the best interests of other NPA members or the best interests of Ash Soni."

Looking ahead, Mr Soni says the profession should be optimistic about the future. Yes there are threats and opportunities but it's all about how we make the opportunities work and minimise the threats.

He illustrates his point by describing a presentation by NPA chief executive John D'Arcy in which he talked about a pharmacist struggling to cope with the massive changes to the pharmacy agenda. After a member of the audience said: "Go on then, I'd like to see you put a positive spin on this," Mr D'Arcy replied: "Think about it. At least you've got those problems; five years ago you weren't even part of this game."

Judith Moreton, programme manager at NHS Immunisation Information, anticipates some of the questions pharmacists may be asked about the Government's new immunisation programme for infants

Explaining the new vaccine to parents

The Department of Health announced improvements to the childhood immunisation programme last week. The key changes are to replace the currently used vaccines in the national childhood programme of diphtheria, tetanus, pertussis (whooping cough), polio and Hib with new combined vaccines for babies, pre-school children and teenagers.

This article sets out to explain the changes to the immunisation programme and provides answers to questions likely to be asked by concerned parents.[1]

What is the new vaccine for babies?

Currently, babies aged two, three and four months receive the DTP-Hib (diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib)) jab and an orally-administered, live polio vaccine. From September 27, the same vaccines are being offered as before, but are now combined with an inactivated polio vaccine into one injection called Pediacel. This should be given at two, three and four months of age at the same time as the Men C vaccine but in a different site.

Why has the new jab Pediacel been introduced?

Pediacel uses inactivated polio vaccine instead of live oral vaccine. This is as effective in protecting against polio and does not carry the risk of vaccine-associated paralytic polio, which can occur, albeit rarely, with the live, oral vaccine (one case in more than 1.5 million doses used).[2] It also uses a new five-component acellular pertussis vaccine instead of whole cell pertussis vaccine, which is as effective in protecting babies against whooping cough. The acellular pertussis component is also likely to cause fewer minor reactions such as swelling or redness, particularly in older children.[3]

What vaccine will pre-school children get?

A new vaccine (dTaP/IPV (Repevax)) combining low-dose diphtheria, tetanus, acellular pertussis and inactivated polio) will be administered for pre-school immunisation of children from three years four months to five years of age. This replaces the currently administered DTaP (Infanrix) and OPV vaccines. Later this year another vaccine for this age group, Infanrix-IPV (DTaP/IPV) will be available as an alternative. Repevax or Infanrix-IPV should be given at the same time as the MMR vaccine but in a different site.

What about the teenage booster?

A new vaccine (Td/IPV – Revaxis) combining tetanus, low-dose diphtheria and inactivated polio will be available as a booster for adolescents aged 13 to 18 years.

All these vaccines (Pediacel, Repevax , Infanrix-IPV, Revaxis) are compatible with the currently used vaccines and are also thiomersal-free.

What is thiomersal?

Thiomersal is a mercury-based preservative that has been used in some vaccines, including the previous DTP-Hib vaccine, for over 60 years. It was added to vaccines to prevent contamination. The World Health Organization's Global Advisory Committee on Vaccine Safety (WHO-GACVSiv) recently reviewed the safety of thiomersal and concluded that there is no evidence of toxicity in infants and children (or adults) exposed to the levels of thiomersal in vaccines. The UK's advisory organisations on vaccines have also reviewed the evidence and found no problems associated with the use of thiomersal in vaccines.[5] This also satisfies internationally-agreed aims to reduce the exposure of children to mercury from avoidable sources.

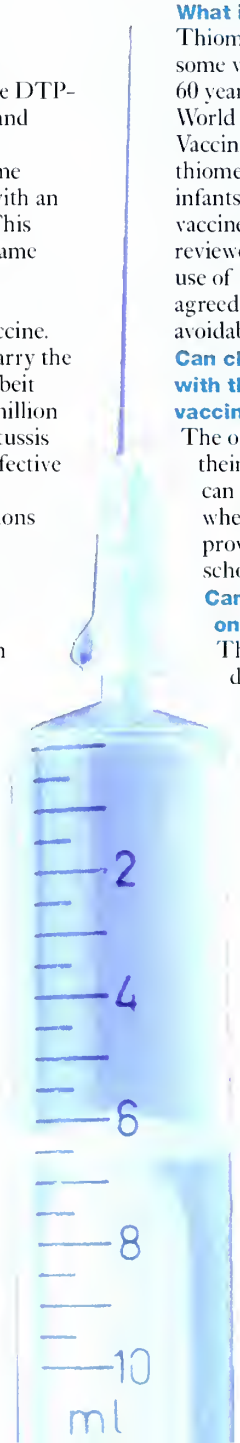
Can children who have had part of the immunisation course with the existing vaccines complete the course with the new vaccines?

The old and new vaccines are compatible. If a child has started their primary immunisation course with the old vaccines, he/she can complete the course with the new vaccines. It does not matter whether they have had one or two doses. Full protection will be provided so long as the course of three doses in infancy, a pre-school booster and a teenage booster is completed.

Can a child's body cope with so many vaccines at any one time?

The vaccines that babies receive in the first year of life are just a drop in the ocean compared to the tens of thousands of bacteria and viruses in the environment that babies cope with every day. The immune system of an infant can respond to about 10,000[6] vaccines at any one time.

References available on request or see www.dotpharmacy.com



When to immunise	What is given	How it is given
2, 3, 4 months	Diphtheria, tetanus, acellular pertussis, inactivated polio vaccine and Hib (DTaP/IPV/Hib) Men C	One injection
About 13 months	MMR (measles, mumps and rubella)	One injection
3-5 years (pre-school)	Diphtheria, tetanus, acellular pertussis, inactivated polio vaccine (dTaP/IPV)	One injection
10-14 years	BCG (against tuberculosis)	Skin test, then if needed an injection
13-18 years	Diphtheria, tetanus and inactivated polio vaccine (Td/IPV)	One injection

Information for pharmacists

- The first delivery of Pediacel, Repevax and Revaxis will be issued by allocation from week commencing September 20. By October 1, all GP surgeries and pharmacies will have received their first delivery, which will be four weeks' worth of supply of each new vaccine. Needles and syringes for Pediacel only need to be ordered through NHS Logistics Authority.
- Following the first delivery, all further deliveries of Pediacel will continue to be by allocation on a fortnightly basis. Following the first delivery of Repevax and Revaxis, further supplies need to be ordered.
- Any existing stocks of the vaccines to be replaced will be collected when new stock is delivered.
- Existing stocks of Men C vaccines are to be kept for the primary immunisation of babies.

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Contact Debra Thackeray, Chemist & Druggist (Classified), CMP Information Ltd, Sovereign Way, Tonbridge, Kent TN9 1RW. Telephone 01732 377493, Fax: 01732 377179. Internet: http://www.dotpharmacy.com

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Products and services

FREE LEGAL ADVICE

Chemist & Druggist's web site – *www.dotpharmacy.co.uk* – has introduced a service that offers pharmacists free legal advice from a leading solicitors' firm.

The service – dotLaw – is being run with the co-operation of Charles Russell, whose specialist legal fields include pharmacy matters.

Pharmacists are advised to e-mail their questions to – *pharmlaw@cmpinformation.com* – along with their full name and the name of their pharmacy. The latter two details are for *C&D*'s records only – pharmacists' identities will be kept anonymous when the answers are published.

All the questions and Charles Russell's replies, which will be available in two working days, will appear on a new dotPharmacy page called dotLaw.

Shopfitting

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Tax Consultants & Accountants

Another reunion for Chelsea

The Chelsea SoP alumni and lecturers of 1956-59: front row from left: Lucille Crowhurst (née Park), Heather Elliston, Dr Georgina Jolliffe, Rosalind Brenenbaum, Janet Pottle (née Osbourne), Pat Hall (née Gentry). Middle row from left: David Nunn, Mary Burdett, Len Davies, Bob Woodward, Sally Rosenthal (née Rosenberg), Valerie Baynes, Zvi Silver and Anne Savage. Back row from left: Mike Harvey, Bryn Hughes, Dr Geoffrey Jolliffe, Michael Whitefield, Ted Trickey, Tony Armstrong, Richard Hall, Benard Pottle and Mike Frizzell

The class of '59 Chelsea School of Pharmacy graduates is still going strong with another biennial reunion taking place last month.

Since the centenary of Chelsea College in 1996 (by which time it had been subsumed by King's College London), the alumini of the 1956–59 year have been meeting every two years. This year the reunion took place at the Cambridge University Botanic Garden with a tally of 33 (including partners and guests) celebrating.

Guests of honour were a pharmacognosy and pharmaceutics lecturer of the time, Drs Georgina and Geoffrey Jolliffe, who set a science quiz. Georgina was also presented with an Apothecary Rose to celebrate her recent 80th birthday.

The reunions have been organised by Heather Elliston, Mike Harvey and Anne Savage, who all enrolled at the Manresa Road site, just off the King's Road, in the year of the Suez crisis. Mike is already thinking about the next reunion in 2006, the 50th anniversary of the group enrolling. He hopes that even more of the 90 plus students who enrolled that year will come along and join in those celebrations.

A special tea break

Before the Queen went on her holidays, Her Majesty hosted several garden parties at Buckingham Palace. Among those attending was Joan Farmer, a pharmacy counter assistant from the TWJ Mattock Pharmacy in Leicester.

Mrs Farmer has been a member of the British Red Cross for over 40 years, and was accompanied to the event by her husband Terence. "I felt very honoured and privileged to attend such a prestigious event," she said.

While the invitation was to recognise her contribution to the British Red Cross, Terence Mattock points out: "All the staff of Mattock's Pharmacy have been trained by Mrs Farmer in emergency first aid including resuscitation, unconscious casualty, heart attack and bleeding." We presume she didn't have to use those skills out the back at Buck House.

Joan Farmer, dressed for the royal garden party

Latest QBTS winners announced

The latest winners in the *C&D* Quarterly Business Trends Survey Draw can be announced.

First out of the hat and winning the £100 prize is RJ Hewell of Moss Pharmacy, Tintagel, Cornwall. Conor Maguire of Alston Pharmacy, Cumbria, and Manish Shah of Broadley Pharmacy, Ilford, Essex are runners up and each win £50.

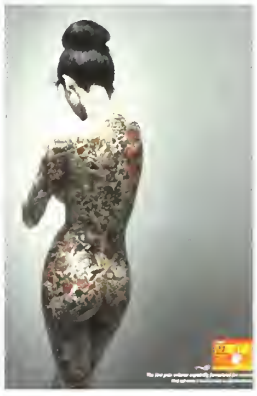
The following have each won £20: Jean Jones, Manchester; Robert Hargraves, Cardiff; Ghada Saleh, London; RP Baillie, Anstruther, Fife; BJ Edmonds, Hereford; Peter Cairns, Lisburn; Jill Hutchings, Edinburgh; KW Craig, St Andrews; D McKullen, Stoke-on-Trent; E Amoako, Stoke-on-Trent; J Al-Mushadani, Newcastle-under-Lyme; R Shah, New Southgate; SG Singer, Edgware; S Bullock, Lichfield; and W McDowall, Waltham Cross.

The survey is sent out to 750 pharmacies four times a year. Anyone interested in taking part should contact Mary Prebble on 01732 377269 or *mprebble@cmpinformation.com*

The power of advertising?

Readers of the Sunday newspapers may have come across an advert for a new brand of analgesic.

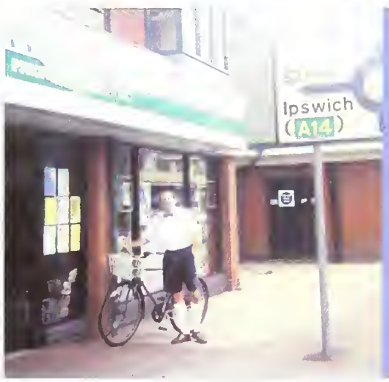
The *Sunday Telegraph* carried a three-quarter page ad last week which featured a naked woman with a near all-over tattoo (pictured). At the bottom (of the ad, not the woman) is a pack of NMA Fematol, offering targeted pain relief for women suffering from headaches, migraines and acute pains. The catch line reads: "The first pain reliever especially formulated for women. Find out more at *www.nmauk.co.uk/painreliever*."



As we have just put the latest edition of the *'Guide to OTC Medicines'* to press, to see this new medicine was a tad worrying.

The good news is that the advert worked as it caught our attention. We even followed it up, such was our interest. But then all was revealed: NMA is the Newspaper Marketing Agency. It has commissioned some research across a sample of 1,300 women, and "as part of the study, a whole variety of brand building ads from different categories were placed in diverse newspaper environments".

But as for misleading the public, doesn't the Advertising Standards Agency have a code against this sort of thing? It's time for the MHRA to step in.



Andalucia is the destination for the latest winner of the *C&D/Community Pharmacy* 'Pharmacy Travel' prize. Irvine Reid (pictured with bike, Bermuda shorts and bow tie) of the Ipswich Co-operative Society Pharmacy in Felixstowe says he will take his wife to Spain this October. "We are both really looking forward to it," he said

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Date of preparation: May 2004 NFN654

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